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THE INFLUENCE OF STIGMA ON HELP SEEKING ATTITUDES FOR
DEPRESSION

by

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Submitted to the Doctoral Faculty
of the School of Nursing in partial fulfillment
of the requirements for the degree of
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2

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APPROVAL OF FINAL REPORT OF DISSERTATION

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THE INFLUENCE OF STIGMA ON HELP SEEKING ATTITUDES FOR DEPRESSION

Margaret Jordan Halter, PhD, RN

Duquesne University, 2003

Major depression is a common, debilitating, and life threatening illness, and its treatment may be hampered by stigma. There have been a limited number of studies that link stigma and help seeking attitudes for depression. The purpose of this descriptive correlational study was to identify the relationship between stigmatizing attitudes and help seeking behavior. Also of interest was the impact of person-level variables that may be associated with a person's desire to seek help. Goffman's Stigma Theory and Weiner's Attribution Theory served as theoretical foundations. Data were collected by questionnaires distributed to patients ($N = 117$) waiting to be seen in both a suburban primary care facility and an urban public health department in Northeast Ohio. The Attribution Questionnaire was used to measure stigmatizing attributions, emotions, and behaviors in regards to depression, and help seeking attitudes were examined using the Attitudes Toward Seeking Professional Psychological Help Scale. Inferential statistics revealed that certain stigmatizing factors were associated with help seeking. The attribution that people are responsible for being depressed was inversely related to seeking help, and the emotional response of pity was positively correlated. Some stigmatizing factors - dangerousness, fear, avoidance, coercion, segregation, and anger - were not significantly associated with help seeking for depression. As expected, there

was a statistically significant difference between female and male responses to help seeking, and between Caucasians and non-Caucasians. Females and Caucasians more likely to endorse help seeking, though this result may have been influenced by the greater proportion of males in the non-Caucasian sample. No significance was found among the person-level variables of political or religious liberalism, nor familiarity with depression. Help seeking for depression may be enhanced if people believe that the illness is not under personal control, that is, that depression is an illness like any other. This study demonstrates the continued significance of the stigmatization of depression and identifies specific populations, such as males and non-Caucasians, who are at greater risk for underdiagnosis and undertreatment.

Dissertation Advisor: Kathleen L. Sekula, PhD, RN

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I. INTRODUCTION

A. Background

The Surgeon General's Report on Mental Health included an imperative that stigma be addressed by mental health professionals (Satcher, 1999). The public's stigmatization of mental illness is cited as being a leading cause of the underdiagnosis and undertreatment of mental illness (Satcher, 1999). While 28% of the population suffers from mental illness, only 8% are diagnosed and treated (Reiger et al., 1993). A goal of the National Institute of Mental Health (2000a) for the treatment and prevention of mental illness is to expand research in order to better understand the variables that underlie the stigmatization of people with mental illness.

Once individuals are diagnosed, treatment adherence is often compromised due to the patient's experience of being stigmatized (Sirey, Bruce, Alexopoulos, & Meyers, 2000). Searle (1999) identifies preconceptions about mental illness and misinformation regarding psychoactive medication as contributing to the delay of diagnosis and in treatment adherence. Additionally, stigma is reinforced by negative attitudes of health professionals themselves (McGaughey, Long, & Harrison, 1995).

Stigma is the perception that an individual is flawed; this discrediting flaw is frequently exaggerated and misunderstood. It is covertly or overtly linked to some personal defect such as a moral failing or limited willpower in the individual who is being stigmatized (Satcher, 1999). The basis for stigma is a fear of what is not

understood, indicating a lack of knowledge on the part of the perceiver or person judging, or a misperception about mental illness. The focus on the perceived flaw results in the reduction of our understanding of the other "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 12).

The mental illness of focus for this study will be major depression. The most common psychiatric disorder, depression is expected to be the second leading cause of disability by the year 2020 (Murray & Lopez, 1997). Kessler et al. (1994) found that 17% of 8,098 respondents age 15-54 had a history of at least one depressive episode, and that 10% had an episode in the preceding 12 months. Depression's financial burden on employers is about \$70 billion annually in the form of medical expenditures, lost productivity, and other costs (Tanouye, 2001). Depression is potentially fatal. Of the 30,000 Americans who commit suicide every year, 90% have some mental disorder, often depression (Hyman, 2000).

Individuals with mental illnesses such as schizophrenia and alcohol or substance abuse bear the greatest burden of stigmatization due to the public's perception of potential violence (Penn, Kommana, Mansfield, & Link, 1999). By comparison, depression is seen as more commonplace, the sort of thing that can happen to anyone (Phelan, Link, Stueve, & Pescosolido, 2000). Though the stigmatization of other mental illnesses may be more intense, the stigmatization of depression is devastatingly commonplace and destructive.

Legally, individuals with depression may have limited protection against stigmatizing responses (Americans With Disabilities Act, 1990). As a nation, Americans promote the rights of the individual and are largely intolerant of discrimination. Discrimination has been met with social protest, informal social pressure, and formal law.

Individuals with physical or mental impairments are legally protected against *de jure* discrimination through the Americans With Disabilities Act (1990). This national mandate covers disabilities that limit major life activities. However, individuals suffering from depression are often caught in a legal gray area, suffering from *de facto* segregation, as there is a problem defining what exactly is meant by a "major" life activity (Starnes, 1999). Furthermore, as opposed to physical illness, depression is more difficult to recognize, and is often indistinguishable from "bad behavior" by the layman. As the result of rampant stereotypes, people with depression fear retribution and harassment should they seek help, and often suffer in silence (Bayer & Peay, 1997).

In order to address the stigmatization of depression, mental health care professionals will benefit by an increased understanding of the degree of this problem and its origin. While it is generally accepted that depression and treatment for depression are stigmatized, it is not clear whether there are person-level variables, or demographic characteristics, that may be associated with stigmatizing activities. Identifying these variables will aid in the identification of groups who are less likely to seek help. Once identified, interventions can be developed in order to promote mental health care within these groups. Furthermore, knowledge concerning how stigma influences help seeking attitudes will provide groundwork for further study and intervention.

The pervasive and destructive problem of stigmatization of mental illness has been underscored by the Surgeon General's Report on Mental Health (Satcher, 1999). Major depression is a common, debilitating, and life threatening illness and treatment may be hampered by stigma. There have been a limited number of studies that link stigma and help seeking attitudes for depression. In order to address this problem, this

study focused on how depression is stigmatized, and how this stigmatization is related to help seeking behavior. Person-level variables were examined in order to understand at-risk individuals or groups. The population of interest was the potential consumer, that is, any adult who could experience depression.

B. Purpose

The overall purpose of this study was to address the issue of stigmatization of depression from the perspective of the potential consumer. The specific aims were (a) to describe the relationship between stigma and help seeking for depression, and (b) to describe variables that are associated with help seeking attitudes.

C. Research Questions

The following research questions guided the inquiry:

1. What is the relationship between stigmatizing attitudes regarding depression and professional psychological help seeking attitudes?

Hypothesis – There will be an inverse relationship between stigmatizing attitudes and intention to seek help for depressive symptoms.

2. What are the relationships between person-level variables (gender, race, political affiliation, religious affiliation, and familiarity with depression) and help seeking attitudes?

Hypothesis – Women will be more likely than men to endorse help seeking for depression.

Hypothesis – Caucasians will be more likely than racial and ethnic minorities to endorse help seeking for depression.

Hypothesis – A positive relationship exists between both political and religious liberalism and help seeking attitudes.

Hypothesis – Familiarity with depression, either through personal or significant other experience, is associated with help seeking attitudes.

D. Definition of Terms

Help seeking attitudes – receptivity toward seeking professional help for psychological problems. For the current study, intention was implied by responses to a measurement of attitudes for seeking professional help. The shortened form of the Attitudes Toward Seeking Professional Psychological Help was used to measure help seeking attitudes (Fischer & Farina, 1995).

Major Depression – Criteria for this diagnosis are five or more symptoms including depressed mood, diminished interest and pleasure in activities, weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, diminished concentration, recurrent suicidal ideation. One of the symptoms must be either depressed mood, loss of interest, or pleasure. Symptoms represent a change in previous functioning and have been present for a two-week period. (American Psychiatric Association Diagnostic and Statistical Manual for Mental Disorders, IV Edition Text Revision (DSM-IV-TR), 2000).

Mental health professionals – those individuals with advanced knowledge of the diagnosis and treatment of psychiatric disorders. These professionals are identified by the

National Institute of Mental Health as psychiatric nurses, psychologists, psychiatric social workers, and psychiatrists (Spearing, 2002).

Religious affiliation – pertaining to "an organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding one's relationship and responsibility to others in living together in a community" (Koenig, 2001, p. 18). Religious affiliation was categorized according to a typology that takes into consideration denominational doctrines, history, and liberalism/conservatism (Green, Guth, Smidt, and Kellstedt, 1996).

Stigma - possessing an attribute that is deeply discrediting, resulting in global devaluation of the individual (Goffman, 1963). Stigma is "another term for prejudice or negative stereotyping" (Corrigan & Penn, 1999, p. 766). Two perspectives of stigma are relevant, a. Public stigma refers to the societal devaluation of those who are different, and b. Self stigma is the experience of being stigmatized, the internalizing of negative valuations, and the attempt to conceal the discrediting flaw (Wahl, 1999).

In this study, stigma was measured by the Attribution Questionnaire (Corrigan et al., in press) which elicited attributions (ascribing traits to another person or group) concerning a depressed individual.

E. Assumptions

1. Stigma, depression, and other psychosocial concepts can be quantified, measured, and correlated.

2. Prior published research upon which this study was based was of sufficient rigor to provide a valid and reliable framework.

3. The data collection instruments were reliable.

4. Subjects self-reported accurately on the data collection instruments.

F. Limitations

It is an arduous task to uncover the sources of beliefs and attitudes regarding mental illness and its treatment, but one worthy the effort due to the magnitude of the problem. A careful and comprehensive review of the literature provided a sound foundation and direction for this study. However, as with all studies, limitations were addressed in order to clarify the choices that were made, and to explore options for dealing with these limitations in the future.

Person-level variables for examination in this study were selected because of their potential to mediate stigma and help seeking attitudes. This identification was based on the relevant literature, the pilot study, and the researcher's personal observations as a nurse working in mental health. There are likely other person-level variables that are relevant to stigma and help seeking that are worthy of future investigation and discovery.

G. Significance to Nursing

Nurses are the largest group of healthcare providers in the United States. In March 2000 the total number of registered nurses was estimated at 2,696,540 (U.S. Department of Health and Human Services, 2001). According to a CNN/USA Today/Gallup Poll (Gallup Organization, 2002), the public ranked nurses number one in

terms of honesty and ethical standards (followed by one year at number two and two years at number one). Because of this respect, their potential influence on the public in terms of attitudes toward depression and its treatment, both in professional and personal interactions, is noteworthy. Furthermore, economic pressures and consumer demand will provide an impetus for nurses to provide more direct care to the mentally ill placing nurses in an even greater position of advocacy (Halter, 2002).

Within the profession of nursing, there is no specialty area or subgroup that is unaffected by issues related to mental health and illness. Nurses employed outside of a psychiatric setting routinely encounter individuals who have mental illness – being employed in intensive care, maternity, or orthopedics does not preclude contact with this segment of the population. Due to the existence of mental illness stigma, it is quite likely that many of the patients that nurses care for are undiagnosed and/or undertreated. Entry into the healthcare system for other health issues may place nurses in a position to assess and intervene to counter the influence of this stigma and facilitate help seeking.

Outside of the acute-care/hospital setting, the development of a knowledge base regarding the stigma of mental illness would assist nurses who are increasingly community-oriented. Stigma has inhibited research and programmatic support aimed at health promotion and prevention for the mentally ill, and has resulted in premature death and high rates of medical comorbidity (Farnam, Zippel, Tyrrell, & Chittinanda, 1999). An understanding of person-level variables that influence the likelihood of help seeking could aid in the identification of and interventions for at-risk groups.

II. THEORETICAL FRAMEWORK

The state of knowledge in mental health regarding stigma is rapidly expanding, in part due to the Surgeon General's Report on Mental Health (Satcher, 1999). Theories that describe the phenomenon of stigma have been put forth by various researchers and theorists, mainly originating from social science and psychology. Two of the most well-known theoretical frameworks will be presented and used as a basis for the present study. These frameworks have been tested extensively and used in numerous studies pertaining to stigma. They are Goffman's Stigma Theory (1963), and Attribution Theory (Weiner, 1995).

A. Stigma Theory

The stigmatization process has been viewed from various perspectives. Goffman, a sociologist, is often associated with stigma theory and research. He defined stigma as “an attribute that is deeply discrediting” which results in a “spoiled identity” for the individual (1963, p. 3). According to Goffman, the possession of a deviant attribute results in global devaluation of the individual; this devaluation creates a lack of respect, marginalization, and an assumption that he or she is not fully human and unable to fulfill the requirements of social interaction.

Goffman emphasizes the need to draw distinctions between those who are stigmatized and ourselves; we do this in order to protect ourselves from the thought that

we could somehow be similarly afflicted. To bolster that protection we emphasize the “differentness” of the afflicted by imputing or attributing “a wide range of imperfections on the basis of the original one” (Goffman, 1963, pp. 15-16). Unstigmatized individuals respond to the stigmatized with anxiety, fear, aversion, and loathing; even nominally positive responses such as pity can be interpreted as emphasizing differentness.

The belief that the individual is flawed is not confined to the perceptions of others, but may also be internalized by the stigmatized individual (Goffman, 1963). The nature of the stigma forces them into what Goffman terms as “discredited” or “discreditable” groups (1963, p. 42). Discredited groups are comprised of those whose stigma is hard to conceal, such as someone with a missing limb, and of those whose stigmatizing condition has been made known to others. For the discredited, others know the stigma before they really know the person. Discreditable groups are comprised of those who have stigmas that are not known. For example, alcoholics are often able to conceal their deviant identities. Disclosure or discovery of the stigmatizing condition results in a shift from a discreditable person into a discredited one.

Impression management, or presenting oneself in such a way that the stigmatizing condition is minimized, or is less likely to be discovered, becomes an important focus to prevent social or internal devaluation. For those who have discredited identities, the damage is done, and the issue is how the resulting tension should be managed in order to successfully interact with others (Goffman, 1963).

For those who have discreditable identities, the damage is not yet done, and the focus is on how it can be avoided, particularly through information control (Goffman 1963). Those suffering from a discreditable stigma are forced to limit the access of

others to information about the stigma, or risk assuming the character of a discredited individual. There is a price to be paid for successfully concealing the stigmatizing condition. When those with discreditable identities attempt to pass themselves off as "normal," social interaction is impeded by feelings of ambivalence and alienation.

Not all people engage in stigmatization to the same extent. According to Goffman (1963), there are two specific groups who may demonstrate compassion for or relate to the stigmatized person. Logically, those who are similarly stigmatized comprise one of those groups. The other group consists of those who are connected to the stigmatized individuals; this connection may be through a personal relationship (relative or friend), or it may be through a professional relationship that is brought about by the "deviance" or condition.

B. Attribution Theory

The process involved in stigmatization is a societal issue that results from a negative social perception. This social perception can be better understood and explained through the general approach or theoretical perspective of attribution theory. Simply stated, attribution theory is based on the insight that humans have an inherent need to explain the causes for everything that happens, and that these explanations make the world more meaningful (Reber & Reber, 2001). The actions and behaviors of people are explained by referring them back to a causal source.

Fritz Heider's (1958) interest in how people attempt to understand the world led to a formal theory of attributions. Heider proposed that people act on the basis of their beliefs (valid or not) and that beliefs must be recognized in order to account for human

behavior. He examined how the ordinary person makes judgments about or explains behaviors and events in their own lives or in the lives of others. Key to these explanations is whether the behaviors were viewed primarily as being influenced by external factors, or by internal factors. For example, receiving a 68% on an exam could be attributed to external factors such as a lousy teacher or an unfair exam. The low grade could also be attributed to internal factors such as a poor disposition, intellectual deficits, or lack of motivation. The type of attributions that we make can be based on our own personal experience, meanings, and perceptual style and are strongly influenced by public attitudes.

We seek explanations not only for the behavior of others, but also for our own behavior, though we are more charitable in regards to ourselves. We tend to explain the behavior of others with reference to internal traits or motivations and thus to hold them more responsible than the situation may warrant. Likewise, we tend to blame the situation, or external factors, for our own actions. This sort of thinking is termed the fundamental attribution error (Reber & Reber, 2001).

Heider (1958) believed that we develop attributions of others to find clarity in what might otherwise be confusing and contradictory information, and it is part of a natural desire for order. Beyond providing order, attributions provide a measure of safety by helping us to predict future events despite limited information. These attributions thus form expectations for the behavior of others, as well as a grid by which their behavior is interpreted.

Weiner (1995) expanded attribution theory's usefulness, and provided a theoretical framework for understanding stigmatizing attitudes and discriminatory

behavior. Weiner (2000) describes humans as scientists who need to understand themselves and the world around them. This understanding is imperfect and there is a tendency to make value judgments of ourselves and others, and then act on the basis of these judgments.

Weiner (2000) identified three perceptions that we use to explain the causes of others' behavior: the locus, stability, and controllability. The locus, as previously described, refers to whether the cause is perceived as being internal or external, that is, something within the person or outside the person. This perception will influence the degree to which the person is seen as responsible for his or her behavior. In regards to mental illness, if aberrant behaviors are attributed to an internal flaw or character trait, people will tend to respond with derision or negativity. If, however, there is an external cause for aberrant behavior such as stressful experiences or a genetic predisposition, people will be more charitable and less prejudiced (Corrigan, Markowitz, Watson, Rowan, & Kubiak, in press).

Humans seem to be especially motivated by the causal attributions of stability and controllability. Our judgments of others, and the affective and behavioral responses to them, can be traced to these causal evaluations (Corrigan, 2000).

Stability refers to duration or permanence of a condition, or how likely it is to change. The more stable a mental illness is viewed to be, the less likely the condition is perceived to be helped through therapeutic interventions (Corrigan, 2000). For example, if schizophrenia is viewed as non-responsive to medication or psychotherapy, then it is viewed as a stable, non-improving condition. Helping a person with schizophrenia could be perceived as a waste of time and a poor investment of resources.

Controllability refers to causes that are subject to volitional alteration (Corrigan, 2000). If the brakes fail on a car and a pedestrian is hit, there is no moral (or legal) culpability because there was no control over the car and brake failure could not be anticipated. However, if a drunk driver hits a pedestrian, moral culpability increases, both because drinking excessively was a choice and because driving recklessly was foreseeable. Intentionally running over someone with a car creates still higher culpability.

Controllability is especially linked to discrimination for mental illness. The more control those with mental illness are thought to have over their condition, the more likely people will be to assign blame and ascribe responsibility. The degree of perceived controllability will influence whether people will affectively respond with pity or with anger. These emotions influence the behavior toward those with mental illness. Pity will likely be linked to a desire to help the individual, while anger may lead to a punishing behavior such as segregation (Corrigan et al., in press).

Dangerousness is an additional perception connected with mental illness that reinforces stigmatizing attitudes (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). The public tends to perceive those with mental illness as dangerous, violent, and unpredictable (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). This stereotype of the mentally ill as dangerous causes fear, which leads to such behaviors as avoidance and social distancing.

Stigmatizing attributions can improve, and familiarity has been demonstrated as one method by which this can be accomplished (Corrigan, Green, et al., 2001). In accordance with attribution theory it makes sense that the nation's attention to the stigma of mental illness exists simultaneously with the development of biologic theories of

causation and more sophisticated treatment methods. As society begins to accept that persons with mental illness may not have control over their condition, the mentally ill are more likely to be pitied than scorned, and helped rather than punished (Weiner, Perry, & Magnuson, 1988). As sophistication in the treatment of mental illness through psychopharmacology advances, the view of mental illness as intractable is diminished.

III. REVIEW OF THE LITERATURE

Stigma research frequently focuses on mental illness, indicating its status as a highly stigmatized phenomenon. The stigma of mental illness has been examined from the viewpoint of consumers, caregivers, and the general public. As part of the overall interest in discrimination, devaluation, and stereotyping, researchers have developed tools by which to measure stigma and stigmatizing attitudes. Though mental illnesses that are perceived as dangerous (schizophrenia), or self-inflicted (substance abuse) are most frequently studied, the stigma of depression has received attention in the literature and is becoming increasingly important in the national research agenda.

Help seeking has been examined in regards to those who are reluctant to seek help. This examination has occurred from various disciplinary perspectives, including sociology, medicine, psychology, nursing, and social work, and included the study of different variables. Among the variables are the ones of interest in the current study: gender, race, political affiliation, religious affiliation, and familiarity with depression.

A. Stigma and Mental Disorders

The general source of stigmas is a reaction to that which is considered a deviation from normal, particularly when that deviation is associated with dangerousness, incompetence, and social inferiority. Individuals who are stigmatized in the United States include homosexuals, racial and ethnic minorities, women, those with physical

disabilities, those with mental disabilities, certain religious affiliations, and those who are overweight (Crocker, Cornwell, & Major, 1993; Harvey, 2001).

The tendency to stigmatize others is not a new one, individuals and groups have always been stigmatized. Leprosy, a historically stigmatized illness, serves as a familiar frame of reference for the problems associated with stigma. This is a disease associated with fear – fear of contagion and fear of the disfigurement, and personal responsibility in that "dirty" people were thought to contract leprosy (Vlassoff, Khot, & Rao, S., 1996). Leper colonies were established to physically distance these stigmatized people from "normal" others and the spoiled identity was internalized by those with the disease.

Fortunately, our understanding and treatment of leprosy have increased, and the stigmatization has decreased. Current social stigmas continue to be dictated by fear and misunderstanding and the degree to which the individual can be held responsible for its occurrence. The stigmatization of homosexuality (Gershon, Tschann, & Jemerin, 1999) has been magnified during the past two decades by AIDS, and falls into the category of a "blame the victim" sort of problem (Fife & Wright, 2000). Likewise, alcoholism and drug addiction are viewed as self-inflicted problems that carry the additional characterization of unpredictability and dangerousness (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Other illnesses and states that are cross-referenced with stigma are herpes (Williams, 1994), epilepsy (Westbrook, Bauman, & Shinnar, 1992), and ageism (Herrick, Pearcey, & Ross, 1997).

In the literature, stigma is frequently associated with mental illness. This stigmatization assumes many forms, grounded in flawed understanding, and resulting in improper treatment. Mental illness has long been viewed with fear and hostility.

Individuals suffering from a mental illness were shunned, exorcised, subjected to bloodletting, along with a variety of other inhumane treatments, and as recently as the 20th century, a lobotomy was considered an appropriate treatment for severe psychopathology (Wahl, 1998). Pirisi (2000) describes the contribution of stigma to “the long silence that has kept mental illness locked away in asylums, and harboured as dirty family secrets not to be mentioned to neighbours or employers” (p. 1908).

By comparison, current treatments are sophisticated. Since the 1950s our psychopharmacologic arsenal has grown dramatically, as has the public’s knowledge of mental illness (Satcher, 1999). Discoveries of an association between genetics and mental illness promoted news media optimism that cures were on the horizon, and spurred greater public interest and focus on genetic causation of mental illness (Conrad, 2001). Though this increased knowledge regarding mental illness is undoubtedly one of the neutralizers of stigma (Corrigan, River, et al., 2001), the problem extends beyond education. Ostensibly, healthcare givers would be among the most educated regarding mental illness, yet there are reports from consumers that mental-health caregivers themselves disparage the mentally ill (Wahl, 1999).

Despite dramatic advances in the understanding and treatment of mental disorders, people with mental disorders continue to suffer not only from their illness, but also struggle with the additional burden of being negatively stereotyped. Mental illness is the leprosy of the 21st century, and is responded to with fear, distance, and blame (Link et al., 1999). Media portrayals present a demeaning and trivializing tone about mental illness, reflecting and shaping the view of society at large (Lazar, Gabbard, & Hersh,

1993). News reports perpetuate myths by framing mental illness in the context of dangerousness and the cause of violent crimes (Crisp, 2001; Smellie, 1999).

B. Stigma Research and Measurement

Mental health professionals and other researchers have recognized the societal and individual importance of stigma as it pertains to mental health. To this end they have developed research and tools by which stigma can be measured.

In the United States, the General Social Survey (GSS) (National Opinion Research Center, 1996) is administered biennially to provide information regarding public attitudes. In 1996 the GSS contained the Mental Health Module, designed to measure attitudes toward mental illness. This encompassed beliefs about causation, competency and dangerousness, willingness to interact, treatment, coercion, and financing. Persons ($N = 1,444$) from representative Primary Statistical Metropolitan Areas were interviewed. The researchers presented the respondents with vignettes that represented various mental illnesses, and then measured attitudes about those illnesses on a modified Likert scale. The GSS data indicate that while the public has more sophisticated views of the causes and nature of mental illness than they did 50 years prior, there has been no significant change in fearfulness or distancing from persons suffering mental health alterations (Link et al., 1999). The authors concluded that stigmatization still profoundly affected help-seeking and social well-being in those with mental illness.

Further analysis of the GSS data (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999) indicated that the public generally believed that persons with alcohol or

drug problems and persons with schizophrenia were dangerous and unable to care for themselves. Research indicates a correlation between the perceptions of dangerousness and fear, and between fear and social distance (Corrigan, Green, et al., 2001). The results were more equivocal concerning public perceptions of depression, as the public did not as strongly endorse items equating fear and depression in the vignettes.

In the United Kingdom, data were gathered as part of a campaign to reduce the stigma of mental illness (Crisp et al., 2000). A survey was conducted regarding public opinions about people with mental disorders. Disorders included depression, schizophrenia, panic attacks, dementia, eating disorders, drug addiction and alcoholism. Questions concerning these disorders were derived from stigma literature and included the themes of dangerousness, unpredictability, being unskilled socially, blame, self-control of illness, and lack of amendability to treatment. Interviews of 1,737 adults were conducted to determine their knowledge and attitudes regarding mental illness. The results revealed a surprising degree of knowledge about mental disorders which, counter to intuition, did not correlate with decreased stigmatizing attitudes. Age was also unrelated to attitude, the young were just as likely to stigmatize. As in the United State's GSS, people with mental disorders (usually schizophrenia, alcoholism, and drug abuse) were thought to be dangerous and unpredictable. All disorders were thought to reduce social ability and made them difficult to talk to. The combination of beliefs that the mentally ill are dangerous, unpredictable, and social disabled perpetuate social distancing and prevent familiarity with the realities of the illnesses.

Qualitative studies have been conducted to gain an understanding of the basic experience of stigmatization. Weiner (1999) interviewed eight university students with

mental illness and identified stigma as a significant aspect of being a student at the university. This stigma impacted their identity, the management of their illness, and their role as students.

In interviews with 25 women diagnosed with mental illness, Cogan (1998) found that child custody was a problem. In such cases, a theme emerged that the woman diagnosed with mental illness felt that they were guilty until proven innocent, that they had to prove they were capable of caring for their own children. Women were also the subject of a study by Copeland (1997) who found that stigma was a barrier to treatment for substance abuse issues. An ethnographic approach in a day treatment facility for mental health clients (George, 2000) revealed that respondents felt stigmatized by the general public due to fear, lack of knowledge, and lack of contact with the mentally ill.

Tools have been developed to examine stigma from the perspective of individuals who are affected by stigmatizing attitudes. Harvey (2001) developed and tested an 18 item stigmatization scale by examining the social stigma associated with being a member of a minority, and measured negative stereotyping, prejudice, and discrimination. A major focus for this study was the perspective of the stigmatized, that is, how much the stigmatizing attitudes were internalized. The sample consisted of 197 European Americans, African Americans, and Native Americans recruited from U.S. universities and enrolled in introductory psychology courses. Harvey found that African and Native American students reported higher stigmatization scores. African Americans who attended predominantly black universities reported less stigmatization.

Link (1987) developed a 12 item scale to measure devaluation and discrimination beliefs in regards to people with mental illness. It was administered to community

residents (with and without a history of psychiatric illness) and to patients on an inpatient psychiatric unit. He reported a reliability of .78 for the scale in this study. Link found an association between devaluation and discrimination beliefs and demoralization, income loss, and unemployment in respondents who had been labeled as having a psychiatric diagnosis.

Link, Cullen, Struening, Shrout and Dohrenwend (1989) used the devaluation/discrimination scale with psychiatric patients and untreated community residents to examine the negative influence of labeling on the mentally ill. While all subjects tended to have negative conceptions of mental illness, the patients had to reconcile these conceptions with their label or diagnosis. The degree and nature of the internalization of this label related to the level of social withdrawal and secrecy, as well as feelings of social connectedness. The authors concluded that labeling and stigma increased the vulnerability of an already vulnerable population by increasing isolation and alienation, thereby decreasing support.

From the perspective of the consumer, a longitudinal study examined the existence of perceived stigma in men before and after treatment for the dual diagnoses of mental illness and substance abuse (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). It was proposed that the perception of stigma may be, in part, the result of depression's tendency to cause negativity and sensitivity. The authors interviewed 84 men diagnosed with both a mental disorder and substance abuse, using stigma as the independent variable and depressive symptoms as the dependent variable. Link's Devaluation/Discrimination Measure contained a series of 39 questions that examined various aspects of stigmatization including devaluation, discrimination, rejection, coping,

and withdrawal. Subjects were interviewed prior to being treated for their addictions and psychiatric symptoms, and then again a year later. There was little difference in the subjects' before and after treatment stigma scores, indicating that "stigma has a substantial and enduring effect on depressive symptoms" (p. 187). They found that despite successful treatment and the abatement of depressive symptoms, there was no change in the men's perception of stigma. The authors concluded that this stigma would influence the subjects' treatment choices in the future.

Professional and public attitudes about mental illness have been measured with The Opinions about Mental Illness (OMI) Scale that was developed by Cohen and Struening (1962). It was originally used to measure stigmatizing attitudes of employees of psychiatric hospitals regarding severe mental illness. It is comprised of 70 items measuring five factors (authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, and interpersonal etiology) on a 6-point Likert scale. In the original study, the authors were concerned with understanding the difference between attitudes of care directors versus caregivers. Significant attitudinal differences regarding the nature and progress of mental illness were found between the two groups based on educational-occupational "hierarchy." In this 1962 study, psychiatrists, psychologists, physicians, and social workers were found to be more scientific and less likely to stigmatize than were nurses, aides, kitchen help, and other non-professional personnel.

The OMI has been modified over the years and continues to be used. Three factors from the OMI (authoritarianism, benevolence, and social restrictiveness) were used in a study by Holmes, Corrigan, Williams, Canar, and Kubiak (1999) to measure stigma prior to and after a course in either general psychology or severe mental illness.

The 83 community college participants demonstrated an improvement of some attitudes regarding mental illness, though the results were influenced by prior knowledge, contact, and attitude.

Wahl (1999) developed a Stigma Questionnaire which was comprised of 28 questions measuring stigma on a 5-point Likert scale to collect data from 1,388 respondents. This descriptive study focused on the perspective of those consumers who have experienced serious mental illness - bipolar disorder, schizophrenia, and major depression. Results indicated that the consumers had experienced stigma through negative reactions from others and thus feared disclosure. These results were compared to responses made by individuals with epilepsy who reported similar experiences, though to a lesser degree.

Weiner (1995) developed a measure to examine attributions related to individuals who were physically and emotionally disabled. Based on Weiner's work, Corrigan, Green, et al. (2001), developed a Psychiatric Disability Attribution Questionnaire (PDAQ) comprised of 36 items on a 7-point Likert scale. The PDAQ measured controllability and stability attributions for four common psychiatric diagnoses (depression, psychosis, mental retardation, and cocaine addiction) and contrasted these with two physical disabilities (cancer and AIDS). The PDAQ was used to measure the influence of stigma-changing strategies on randomly assigned community college students (N=152). The strategies used to change stigma in these groups were protest, education, and contact. Protest was operationalized through a slide presentation that demonstrated disrespectful treatment of the mentally ill, followed by imperatives that it was wrong to treat them this way, and condemnation of the actions. Education included a

review of myths about mental illness. The contact group consisted of one or two persons presenting an overview of their history of severe mental illness. It was found that protest had the least effect on stigmatizing attitudes. Education influenced stigmatizing attitudes in regards to psychiatric disabilities, but not physical disabilities. Contact was determined to be especially helpful in changing stigma related to depression and psychosis.

An Attribution Questionnaire with 21 items was developed by Corrigan and colleagues modeled on the work of Reizenstein in 1986. Corrigan, Green, et al. (2001) administered this questionnaire, along with measures regarding contact and distance to 208 college students. The focus of this study was to examine the effects of familiarity with mental illness on the stigmatizing attitude of dangerousness, an attitude that creates fear and influences social distancing. Familiarity refers to knowledge about and experience with mental illness through varying degrees of contact ranging from least intimate situations (never been aware of another's mental illness) to moderate situations (working with a person with mental illness) to high intimacy (personally having a mental illness). They concluded that familiarity decreases stigma, especially regarding the stereotype of dangerousness, and increases the likelihood of social contact with the mentally ill. The Attribution Questionnaire has been used in subsequent studies with the addition of 6 items for a total of 27; these items represent stigma specifically related to mental illness and include dangerousness, fear, and behavioral avoidance (Corrigan et al., in press).

C. Stigma and Help Seeking Attitudes

That stigma can have profound influence on self-perception and self-esteem is a serious problem. However, when stigma influences help seeking attitudes, resulting in a lack of treatment for mental illness, it can be a life or death issue (Hyman, 2000). A study by O'Connor, Sheehy, and O'Connor (1999) analyzed coroner's inquests for 142 suicides and categorized them in three groups. The first group had some depression, but little health care contact. The second group had frequent depression, a history of self harm, and were sometimes hospitalized. The third group was most certainly depressed, had a history of self harm, and had visited their physician within the past six months. The largest of these groups was the first one in which the individuals did not seek help and did not have a diagnosis of mental illness at the time of their death.

Help seeking attitudes for psychological problems in general have been the subject of numerous research studies. Bayer and Peay (1997) examined attitudes toward seeking help of 142 patients waiting to be seen for primary care in Australia. They concluded that personal attitudes toward seeking help, such as confidence in mental health professionals and their ability to help, were more influential than were social attitudes on decisions to seek mental health services. However, for high school students help seeking was influenced by the behaviors of their peers, that is, they were more likely to seek help for mental issues if their peers did (Gibson & Range, 1991).

Despite the fact that major depression is considered to be the sort of illness that could happen to anyone, there continues to be a marked stigma toward the diagnosis and toward those who are diagnosed with it. Twenty-five percent of the respondents in the public survey undertaken in the United Kingdom (Crisp, 2001) endorsed statements

indicating that individuals with severe depression were dangerous, and twenty percent claimed that these individuals could "pull themselves together." Americans interviewed for the General Social Survey (GSS) (National Opinion Research Center, 1996) identified those with depression as "likely to do something violent to others" at a rate of 33%, and nearly 37% believed that a person with major depression would get better without help. This perception of a lack of need for treatment is supported by the notion that depression was more often attributed to stress (54%) than chemical causation (21%). More than a third of the respondents reported that they were definitely or probably unwilling to interact with an individual with depression.

Importance of stigma in regards to help seeking behaviors for depression has been highlighted by The National Institute of Mental Health's Justification of 2001 Budget (Hyman, 2001). It prioritizes the identification of stigma as an area of research exploration and expansion, with a goal to assist in changing societal attitudes.

D. Person-Level Variables and Help Seeking Attitudes

Some individuals are comfortable with seeking professional psychological help, and others view it as a sign of emotional or spiritual weakness, or an indication of failure. The literature demonstrates person-level variables that may mediate stigmatizing attitudes, and therefore influence professional psychological help seeking. These variables include ascribed factors such as gender and race, and acquired factors such as religious and political affiliation, and experience with depression.

Gender

Some person-level variables have been found to have a relationship to help seeking behavior for depression. One often-cited statistic in regards to depression is that females are two to three times as likely to be depressed as males (National Institute of Mental Health, 2000b). It should be noted, however, that in order to be diagnosed with depression, individuals must seek help, and women have been found to possess more positive attitudes than men toward help-seeking (Bayer & Peay, 1997; Leong & Zachar, 1999). If men do not seek help they will not likely be diagnosed with depression. There have also been studies that suggest that men feel as if their problems are inappropriate for treatment by mental health professionals (Bayer & Peay, 1997). Even when men seek help, they are less likely to be diagnosed with depression since their symptoms tend to be somatic concerns and work-related problems rather than classic depressive symptoms (Vredenburg, Krames, & Flett, 1986).

Depression is a precipitant to most suicides, and in the United States men commit suicide at a rate of four to one as compared with women (Alexander, 2001). More than half of all suicides are thought to be the associated with major depression (Murphy, 1998). The disproportionately high rate of completed suicides among men indicate that men do indeed suffer from depression. However, the absence of antidepressants in the bloodstreams of men who have completed suicide indicates that men are either not seeking help or are not following through on treatment for depression (Murphy, 1998).

Much of the literature has focused on men's fear of vulnerability or the belief that seeking help is unacceptable (Tudiver & Talbot, 1999). It has been suggested that men avoid seeking help for depression since it would be acknowledging a weakness (Murphy,

1998). This perception may also be contributory to the discrepancy between reported incidence of depression and suicide. This is not surprising since men don't seek help for any health concern as readily as do women (Tudiver & Talbot, 1999). Also, it may be that men experience depression in ways that are less obvious to primary care practitioners, and they tend to have more somatic complaints and antisocial behavior (e.g. alcoholism) that may mask the diagnosis of depression (Heifner, 1997).

Race

Race has been cited as a variable that influences help seeking behavior for mental illnesses such as depression. In the United States, members of minorities have cultural, economic, or communication barriers that may deter health care in general.

Van Hook (1999) demonstrated that minorities were more influenced by their community and cultural views, tended to separate medical and emotional problems, and were more likely to use informal sources such as friends and family for help seeking. Minority cultures are less individualistic and value independence less than Americans who are in the majority, placing a greater emphasis on the role of the family. As a result, taking problems outside the home carries with it a sense of disgrace and hence higher levels of stigma within the culture and within the stigmatized individual (Barrio, 2000).

The magnification of stigma of mental illness within minority communities has been identified as a significant barrier to treatment (VanHook, 1999). African Americans are 2.5 times more likely to fear treatment for mental health issues than are whites (Sussman, Robins, & Earls, 1987). African-Americans are more likely to ascribe spiritual causation and treatment for mental illness than are whites, and tend to terminate treatment earlier (Millet, Sullivan, Schwebel, & Myers, 1996). Likewise, African-

Americans were more likely than whites to describe stigma and spirituality as influencing their willingness to seek help (Cooper-Patrick et al., 1997). These factors likely influence their knowledge about mental illness. Zylstra and Steitz (2001) found older African-Americans to be less knowledgeable about depression than their white counterparts, particularly a problem when related to rates of depression among elderly.

Religious Affiliation

Spirituality and religious affiliation have the potential to exert a marked influence on a person's view of themselves and how they interact and respond to others (Mackenzie, Rajagopal, Meibohm, & Lavizzo-Mourey, 2000). Spirituality is "the personal quest for understanding answers to ultimate questions about life" (Koenig, 2001, p. 18) and may or may not be connected with the community or religious rituals. It has increasingly been the focus of research as practitioners strive to incorporate spiritual concepts and coping into holistic practice. In a summary of research between beliefs, spirituality, and health, George, Larson, Koenig, and McCullough (2000) offered some conclusions. Spirituality was found to increase healthy behaviors, social support, and a sense of meaning which were linked in turn to decreased overall mental and physical illness. Specific to mental health, associations have been found between faith and outcomes such as lower anxiety and greater optimism (Pardini, Plante, Sherman, & Stump, 2001).

Religion refers to an "organized system of beliefs, practices, rituals, and symbols" (Koenig, 2001, p. 18). Religious affiliation is a choice to connect personal spiritual beliefs with a larger organized group or institution. How religious affiliation impacts mental health in terms of both counseling and research has been not been given the same

amount of attention as has spirituality (Faiver, O'Brien, & Ingersoll, 2000). This inattention may be due to a reluctance to imply that one organized religion is somehow better than another (Ellison, Boardman, Williams, & Jackson, 2001).

Another explanation for this inattention is that psychology and religion often assume the other has contrary values (Faiver, O'Brien, & Ingersoll, 2000). Psychology has been referred to as the religion of humanism, as humanistic values are thought to be the basis for therapy and therapists (Faiver, O'Brien, & Ingersoll, 2000). The tension between religion and psychiatry was most notable with the demonization of mental illness, especially schizophrenics who were thought to need exorcisms rather than psychiatric care (Dain, 1994). In the United States, there is a perception that non-Christians, especially those of the Jewish faith, are overrepresented in mental health professions, and that psychiatry is anti-Christian (Dain, 1994; Koenig, 2001). From the perspective of mental health, organized religion has often been viewed as a source of psychological pathology and something from which adults need to "recover" (Koenig, 2001).

Research indicates that religious persons may use mental health services less because they actually need them less (Ellison & Levin, 1998). Individuals who are active in their churches are found to cope better and suffer from less anxiety, have a lower rate of suicide, and are less likely to be depressed (Koenig, 2001). Involvement in religious communities include supportive human relationships, spiritual encouragement, and access to pastoral counseling, all of which play stress-buffering roles (Mirola, 1999).

Miller and Eells (1998) found that higher levels of religiosity were associated with both a greater interpersonal openness regarding personal problems and a decreased

tendency to be influenced by the stigma of seeking psychological help. However, this openness and tolerance did not translate into recognition of a need for help or to have confidence in the efficacy of therapy. We are uncertain as to how different religious affiliation may exert influence over depression and need large prospective studies to examine this relationship (Koenig, 2001). Many denominations are either overtly or covertly hostile to some aspects of psychology and its basis in humanism. Koenig, in an interview with Hsu (1995), identified the influence of a person's religion on help seeking choices for mental health issues, noting that certain groups, such as those who rely on faith healing, do not seek psychiatric services. Ambivalence regarding help seeking may be due to uncertainty as to whether the problem is one that originates in mental health or spiritual weakness (Koenig, 2001).

Categorizing denominational groups for the purpose of comparison has proven to be a complicated task. Various approaches have been used and each has its drawbacks, primarily since there is little uniformity within denominations. One research approach classifies denominations as liberal or conservative, though this may be criticized for being narrowly focused and inexact. A greater breadth of denominational characteristics are considered in a typology used by Green et al. (1996) and is based on the official doctrines of the denominations, their origins and history, along with a liberal-conservative measure. The premise of this typology is that examining religion based on a liberal-conservative measure is justified since there is an impressive relationship between religion and political attitudes, apart from other demographic and social characteristics.

Green's typology was developed based on a questionnaire completed by a random sample of adults ($N = 4,001$) who responded to questions regarding religious affiliation.

Based on this study, the most conservative denominations were described as having a literal interpretation of scripture, a belief that faith in Jesus is the only way to be saved, emphasis on the importance of a conversion experience, and placing a strong emphasis on missions. In addition to locating persons within denominational traditions, the authors also measure the intensity of belief by inquiring about attendance and how important it is to the individual believer to "follow God's will" and "follow a strict moral code." The more intensely believed, the more conservative are the views for those particular beliefs.

Placing denominations on a liberal-conservative continuum seems to be best suited for majority churches. For Caucasians in the United States religious affiliation is closely related to and influences political ideology and that the choice of a particular affiliation indicates similar ideology (Fowler, Hertzke, & Olson, 1999). Religious affiliation is tempered in minority churches by political and cultural influences. For example, two denominations that are categorized as members of the most conservative group in Green's typology are Southern Baptists and Black Baptists. While both denominations are theologically conservative, Southern Baptists tend to be socially conservative and Black Baptists socially liberal (Fowler, Hertzke, & Olson, 1999).

Political Affiliation

In terms of political affiliation, there is evidence for group disparities in causal thinking which is relevant to stigmatization and help seeking (McSween, 2001). These disparities may be based on a political ideology that stresses individualistic rather than collectivist values. This individual trait tendency, or the tendency to blame the individual, is more prevalent among conservatives than liberals (Farwell & Weiner, 2000).

Most Americans have a particular political affiliation. Studies in political behavior have demonstrated that party identification and political ideology are related to policy attitudes for mental health (McSween, 2001). Political affiliations are associated with how those with mental illness are perceived (especially in regards to dangerousness and responsibility), and the degree of government support for adequate treatment of mental illness. The overall issue of healthcare was named to be the second most important issue in determining their vote in the 2000 Presidential election by 1,183 voters drawn from a national random sample (Kaiser, 2000), and an overwhelming number of those voters believed that Democrats would do a better job dealing with health issues. The degree of support appears to be less for mental health care than physical health care and is likely due to the long history of stigma attached to mental illness (McSween, 2001).

Familiarity With Depression

As previously stated, specific groups may have increased empathy for individuals who are stigmatized (Goffman, 1963). These groups include those who are similarly stigmatized, those who have relatives or friends with the stigmatized condition, and those who have professional relationships with individuals who possess stigmatized conditions.

At the most intimate level of familiarity are those individuals who have themselves suffered from the stigma of mental illness. This level of familiarity may promote mechanisms by which individuals are better able to tolerate and not internalize the stigma (Crocker & Major, 1989). Stigmatized individuals often modify their own negative stereotypes about mental illness, and therefore will have a reduced tendency to stigmatize others in their "in-group."

Research supports Goffman's notion that familiarity mediates prejudicial attitudes. In a study by Corrigan, Edwards, et al. (2001), 151 subjects recruited from paraprofessional training at community colleges completed the Level of Contact Report (LOC) developed by Holmes et al. (1999). The LOC measures to what degree people have had experience with mental illness. Subjects also completed a tool to measure prejudice toward mental illness, along with a scale that assesses acceptable social distance from individuals with mental illness. Familiarity was found to positively influence the prejudicial attributions of responsibility, controllability, and dangerousness. This positive influence, in turn, reduces social distancing.

In a similar study, familiarity with mental illness was found to be related to a decreased tendency to stigmatize in a sample of 208 community college students (Corrigan, Green, et al., 2001). Familiarity was found to reduce the attribution of dangerousness and the behavioral response of avoidance. As in the previous study, familiarity with mental illness was inversely associated with social distance.

According to Phelan et al. (1998) there has been little research regarding family stigma, that is, the stigma that the family feels because of having an ill family member. They did find that 50% of parents and spouses ($n = 156$) attempted to conceal their family member's illness.

Studies have documented changes in nursing students' attitudes toward the mentally ill following psychiatric nursing education and clinical practice. Prior to the experience many students believe that the patients will be "aggressive, hostile, violent, and in straitjackets, and likely to injure them" (Perese, 1996, p. 283). This is in keeping with Goffman's (1963) contention that a professional relationship may bring about

compassion or relatedness with members of stigmatized groups. This may be the result of increased knowledge of and familiarity about mental illness, both of which lead to a decreased tendency to stigmatize (Corrigan, Green, et al., 2001).

E. Summary

This study measured the significance of the public's perception and attitudes regarding depression in determining whether individuals will seek help for depressive symptoms. The use of samples from both a private primary care facility and public health agency strengthened the usefulness of this study by providing a sample that closely approximates the public in the United States. Furthermore, there are few data as to how stigma may influence help seeking attitudes, which is potentially one of the most destructive aspects of stigmatization.

This study also sought to understand how person-level variables mediate the stigma of depression, and how members of the public, or potential consumers, would respond if they were faced with depressive symptoms. Basic person-level variables including gender and race were of interest as to how they may be associated with stigma and help seeking. Religious and political affiliations are two essential and sensitive identities that individuals have. These affiliations may be related to stigmatizing responses and help seeking attitudes. An understanding of the relationship between both the ascribed and acquired person-level variables could aid in health promotion, prevention, and treatment of depression.

IV. METHODS

A. Design

A non-experimental, descriptive correlational study was conducted to determine if a relationship exists between stigmatizing attitudes and the help seeking attitudes an individual would have regarding depressive symptoms. Secondly, relationships were explored between certain person-level variables (sex, race, political affiliation and ideology, religious affiliation, and familiarity with depression), and help seeking attitudes in regards to depression. In this descriptive correlational research the objective was to describe the relationship among the variables. This type of study was chosen in order to collect baseline data and to promote hypothesis generation for future research.

B. Sample

The target population of interest was the general public in the United States (over 18 years of age). While simple random sampling would have been ideal to examine attributes of such an extensive group (the public), cost considerations, and the preliminary nature of the work precluded this method. The sample for this study was derived from patients waiting to be seen in a suburban primary care setting and in an urban public health setting in Northeast Ohio. These settings provided a fairly representative cross section of the area in terms of the variables of gender, age, race, socioeconomic status, religious affiliation (though this affiliation was dominated by

denominations within the Christian faith), and political affiliation. Inclusion criteria were registration with one of the agencies, the absence of acute physical or emotional distress, capacity to give consent, and the possession of a minimum level of cognitive ability. Participants were required to report English as their first language.

Since the questions in the current study are answered through correlational analysis, the correlation coefficients from previous studies were used to estimate the effect size. There were no published studies found regarding stigma and help seeking, however the pilot for this study provided this correlation. The hypotheses related to the person-level variables were conceptually close to r correlations available from other studies, and provided a useful approximation to determine effect size. With a standard alpha criterion of .05, a conventional standard power of .80, and a medium estimated effect size of .31, a sample size of at least 87 was necessary (Cohen, 1988). A sample size of 100 was targeted in order to account for missing or spoiled data.

C. Setting

Two facilities were selected to be the source of subjects for this study. One was a suburban primary care facility staffed by four physicians and a nurse practitioner. The other was the adult health clinic in an urban public health department. This clinic is part of the nursing division of the health department and is staffed primarily by nurse generalists and practitioners, along with medical personnel. It provides services to approximately 14,000 people per year through the communicable disease program, hypertension program, a dental clinic, and a refugee program. Both of these Northeast Ohio settings were chosen to provide a sample that possesses heterogeneity of the

variables under study. Furthermore, these sites were available to the investigator and the managements were receptive to this type of research, and saw a potential educational benefit to their patients.

Institutional Review Board approval was secured from Duquesne University (Appendix E). In regards to the urban setting, the investigator discussed the study with the director of nursing at the Akron Public Health Department. She was receptive and expressed that taking part in the study might promote mental health awareness among their clients. After providing documentation of Duquesne's Institutional Review Board approval, the Director of Akron Public Health granted permission to use the facility and patients in the study (Appendix F). A meeting was arranged at the primary care facility between the investigator, a physician, and the nurse practitioner to discuss the study. Afterward, all primary care providers at this facility were asked for their input, approval was given, and a letter of agreement was drafted and signed (Appendix G).

D. Ethical Considerations

Conceivably, filling out the form, which required the respondent to reflect on the issue of mental illness, and could have been emotionally charged and/or negatively stimulating. Since data were collected by the primary investigator who is an advanced practice nurse and specialized in psychiatric/mental health nursing, if a respondent was to react negatively to this experience the investigator was in a position to assess the individual further and provide emotional support. Additionally, the investigator made arrangements to notify the personnel of the participating agencies if respondents experienced distress or indicated they were depressed. The agency personnel agreed to

follow-up with these individuals either in the office that day and/or through referral mechanisms.

Participants gave informed consent to be included in this minimal risk study. A copy of the consent form was provided to the subjects, and another signed copy (Appendix D) was retained by the investigator to be kept separately from the questionnaires in order to prevent names from potentially being linked to the responses. Completed questionnaires and consent forms were stored in a locked file cabinet to which only the investigator had access. Letters of permission were received from the two agencies that had agreed to participate in this study.

E. Measurement Instruments

Participants completed a Demographic Data Form (see Appendix A). This form consisted of demographic items and person-level variables including gender, age, marital status, race, political affiliation, orientation to political issues, socioeconomic status, religious affiliation, and familiarity with depression.

Questions about race were modeled after the U.S. Census Bureau Report of 2000 (2001). Respondents were asked to identify themselves in terms of both Hispanic origin and race; the federal government considers these identifications to be distinct and separate questions. The first question read, "Are you Spanish/Hispanic/Latino?", and the choices were yes or no. In the second question, they were asked to identify themselves racially. Participants had the option of selecting more than one of the categories to indicate their racial self-identities. Six general racial categories were represented in the

questionnaire and included White, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, or "some other race."

In regards to political affiliation, research indicates that this variable provides a greater breadth of understanding when combined with a question concerning political ideology or orientation to political issues (Farwell & Weiner, 2000). Both political affiliation and ideology were measured on 7-point Likert scales. Support for this type of measure comes from Sears and Funk (1999) noting that using 9-point scales results in very few 1's or 9's, and scales of less than 7 points are inaccurate since they allow for little variation. Additional research supports the use of a 7-point scale (McSween, 2001; McAllister & Wattenberg, 1995) for identifying political affiliation ranging from Strong Republican, to Strong Democrat. Research by Robinson, Keltner, Ward, and Ross (1995) supports classifying participants as liberal, moderate, or conservative based on their response to a 7-point scale ranging from extremely liberal to extremely conservative. The overall distribution of Americans' political orientation is 20% liberal, 23% moderate, 30% conservative, and 27% undecided (National Election Studies, 2000).

Religious affiliation was elicited through questions regarding religious tradition and frequency of church attendance. Choices of religious tradition included Christianity, Judaism, Islam, Buddhism, Hinduism, none, and other. Respondents who identified their overall religious tradition as Christianity were asked to identify a specific denomination.

Categories for Christian denominations were based on a typology by Green et al. (1996) where every major Christian denomination is categorized under five main headings. These headings, listed from most to least conservative, are: Charismatic and

Fundamentalist, Conservative Protestants, Mainline Protestants, Liberal Protestants, and Catholics.

The final section of the demographic data form was the Level of Contact Report (LOC), a scale used to measure familiarity with depression based on the amount and degree of contact the participant has had with depression. This scale is based on work by Holmes et al. (1999), where familiarity was examined in regard to severe mental illness. Since the focus of the current study was depression, the 12 items in this LOC were modified to describe situations in which contact with depression (rather than mental illness in general). Respondents were instructed to select any situation that had occurred in their lifetimes. Each item is ranked from 1-12 in order of least to greatest intimacy. These items range from "I have never observed a person that I was aware had depression" (ranking of 1) to "I have depression" (ranking of 12), and respondents received a final score based on the highest item checked.

The second inventory used (Appendix B) was the Attribution Questionnaire developed by Corrigan et al. (in press). It was developed to examine stigmatizing attitudes, emotional reactions, and behavioral responses toward mental illnesses based on a vignette. This questionnaire was previously used primarily to assess attributions related to severe mental illness such as schizophrenia. The vignette was rewritten by the investigator to reflect depressive symptoms based on criteria for major depression listed in the *Diagnostic and Statistical Manual Mental Disorders DSM-IV-TR, Fourth Edition* (American Psychiatric Association, 2000). An expert in stigma theory reviewed the form and assessed that the vignette changes did not threaten the original psychometric properties (P.W. Corrigan, personal communication, February 20, 2002).

Responses on the Attribution Questionnaire were measured using a 7-point Likert-type scale for 27 items. The scale is broken down into nine factors with three items each. Six factors are derived from attribution theory and address responsibility, affective mediation (anger or pity), and behavioral reactions (help, coercion, and punishment). Three additional factors represent specific issues related to mental illness and stigma – the attribution of dangerousness, the affective response of fear, and the behavioral reaction of avoidance.

The third inventory used (Appendix C) was the shortened form (Fischer & Farina, 1995) of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) developed by Fischer and Turner (1970). This shortened form is composed of 10 items and has a reported Cronbach's alpha of .84 when administered to 389 freshman students (Fischer & Farina, 1995). It has been demonstrated to possess psychometric features matching those of the original 29-item scale (Fisher & Farina, 1995). Responses were measured on a 4-point Likert response format that includes an agree-disagree continuum with no neutral choice. Slight modifications of the items were made with the author's permission to reflect a broader conception of psychological help, that is, counseling options refer to mental health professionals rather than exclusively psychologists. Also, rather than using nonspecific references to psychiatric alterations such as "mental breakdown" or "emotional problem" that were used in the original tool, the specific diagnosis of depression was used where appropriate.

F. Preliminary Study

A pilot study was undertaken in order to refine the research methodology. A sample of baccalaureate nursing students was selected that included freshman, sophomore, junior, senior, and degree completion students. Data were collected over a two week period and 140 measures collected. Of these 140, four surveys were incomplete in terms of missing demographic data, leaving 136 complete and usable measures. The same research questions were used as proposed for the larger study, though no hypotheses were posed. The data were analyzed in terms of descriptive statistics and correlations using the Statistical Package for the Social Sciences (SPSS).

The Attribution Questionnaire was scored by summing the three items for each of the nine factors represented. This sum was then divided by the three items to provide a standard comparison. Higher scores on a factor are associated with a greater tendency to endorse the factor. On the ATSPPHS, higher help seeking scores indicate a pro-help seeking attitude for depressive symptoms. Overall help seeking scores ranged from 5-30 with a mean of 20.8 ($SD = 5.3$).

There was an inverse relationship between the responsibility factor and help seeking attitude ($r = -.24, p < .01$). Lack of endorsement for the responsibility items ("he's at fault," "he can control it," and "he's responsible") was associated with a greater receptivity to help seeking.

In terms of person-level variables, females ($n = 125$) scored higher on help seeking with a mean score of 21.1 ($SD = 5.1$), while males ($n = 11$) had a mean score of 17.5 ($SD = 6.3$). Females were significantly more likely to endorse help seeking for depression than were males ($t = 2.24, p = .027$). Students who were more advanced in

the program and were older had a greater tendency to endorse help seeking. Year in nursing school was positively correlated with help seeking ($r = .31, p < .01$), and age was positively correlated with help seeking attitudes ($r = .18, p < .01$).

Caucasians ($n = 128$) made up 96% of the sample and had a mean score of 20.7 (range 5-30, $SD = 5.3$) for help seeking. Non-Caucasians ($n = 6$) had a mean score of 22.3 (range 14-27, $SD = 4.9$) indicating a greater receptivity to seeking psychological help. Non-Caucasians tended to have an older average age (32 as compared to 25 in Caucasians) and all were female.

In regards to political affiliation, Independents were most likely to seek help, followed by Democrats, Republicans, and undecided. Students identified themselves in a range from extremely conservative to slightly liberal (no one chose liberal or extremely liberal). Those who identified themselves as slightly liberal had the highest help seeking scores of the sample, followed by slightly conservative, moderate and conservative (tied), and extremely conservative.

Christian religious affiliation was divided into five categories according to a conservative-liberal model of denominations (Green et al., 1996). There was a statistically significant difference, $F(22, 96) = 1.7, p = .029$, in help seeking scores based on this typology. Highest help seeking scores were found in the two groups deemed most liberal: Catholic, 23.4 ($SD = 3.8$), and Liberal Protestant, 23 ($SD = 2.8$). The third highest score came from the most conservative group, Charismatic/Fundamentalist, 22.3 ($SD = 3.8$), followed by Conservative Protestant, 20.3 ($SD = 5.2$), and the lowest score came from the moderate group, Mainline Protestant, 19.1 ($SD = 6.2$).

In terms of stigmatizing attributions, emotional responses, and behavioral reactions, there was a relationship between: anger and both age and year in the program ($-.18, p < .05$; $-.20, p < .05$), segregation and both age and year in the program ($-.27, p < .01$; $-.39, p < .01$), and fear and coercion and year in the program ($-.23, -.22, p < .01$). The reduction in negative responses was especially notable in students who had completed requirements for the psychiatric/mental health didactic and clinical components.

This pilot study provided direction for hypothesis generation, though its generalizability was limited by the relative homogeneity of the sample. The current study was strengthened by including a sample with greater gender, racial, religious, and political diversity. Interviewing respondents in a suburban primary care facility as well as a public health setting helped to increase this diversity.

Changes in the study design that resulted from what was learned in the pilot study included the reformatting of the demographic data sheet from two columns to one in order to increase the likelihood that respondents would respond to all items, as some items in the original were missed. In the pilot study, familiarity with depression was assessed by asking if the respondent had experienced depression, or if they had contact with an acquaintance, friend, or family member who had depression. These questions were omitted in favor of a more inclusive, standardized measure, the 12-item Level of Contact Report, developed by Holmes et al. (1999).

G. Data Collection, Analysis, and Interpretation

Collection

Data collection took place in the waiting room of a group of primary care providers, and also in an adult public healthcare setting. After subjects signed in for appointments at either facility they were approached by the researcher who identified herself as a registered nurse, and asked if they would be interested in participating in a study regarding depression. If potential subjects indicated receptivity, the investigator provided a brief oral description of the study in an adjacent alcove, away from the other patients. Subjects were presented with a Consent Form which described the study (Appendix D). The researcher reviewed the consent form with the potential subject. They were encouraged to ask questions, and all questions were answered. Signatures were obtained for the investigator's copy, and the subjects received a copy of the consent form for themselves. Subjects also had the opportunity to ask questions of the investigator prior to filling out the questionnaire and at any point thereafter. They were informed that they did not have to complete the study and could stop at any point.

There was typically a substantial waiting period (usually about 30 minutes) between signing in and actually seeing the physician, nurse, or nurse practitioner. In most cases this was sufficient time to complete the questionnaires. However, some subjects were called into an exam room prior to finishing the survey. When this happened subjects continued to complete the questionnaires in the exam rooms, and sometimes finished them after their healthcare appointment was over.

Analysis

Data were analyzed electronically using SPSS. Verbal labels such as gender were recoded into numeric ones. Responses regarding some of the variables (those that indicate ranges) were coded, as was missing information. Demographic data were summarized. The data were analyzed descriptively examining frequencies, ranges, and distributions of variables. Reverse item questions were recoded. Individual factor scores for the Attribution Questionnaire were summed and divided by the number of questions in each factor to provide a more uniform standard of comparison. The ATSPPHS scale was summed for a total score. The research questions were each addressed and data were organized. In order to analyze the associative hypotheses, correlational analyses were employed.

Research question 1: What is the relationship between stigmatizing attitudes regarding depression and professional psychological help seeking attitudes? An analysis was conducted to obtain a correlational score between specific factors in the Attribution Questionnaire and help seeking.

Research question 2: How are person-level variables (gender, race, political affiliation, religious affiliation, and familiarity with depression) associated with help seeking attitudes? Person-level variables and help seeking attitudes were subject to hierarchical regression analysis with five predictors in the first block (gender, race, political, religious, and familiarity with depression) and help seeking attitudes in the second block. Separate ANOVA's with Bonferroni adjustment were used to address each of the hypotheses.

Interpretation

The results of the study were evaluated for accuracy, meaning, importance, generalizability, and implications. In terms of accuracy, the investigator critically analyzed the research process and assessed the degree to which shortcomings of the study may have reduced the accuracy of the results. In this descriptive correlational study, the data were scrutinized, and other explanations for significant results were explored. Nonsignificant results (those that fail to reject the null hypotheses) were examined in order to avoid a Type II error.

The importance of the study was determined by examining those hypotheses that were statistically significant in terms of whether they are of any value to our understanding of stigmatizing responses and help seeking attitudes. Implications from this study may provide a direction for further studies on stigma and its impact on help seeking behavior. Stigma theory has been extensively tested. This study may add to the existing knowledge-base in regards to our understanding of stigma.

H. Justification of Methodology

In an extensive review of the literature, few studies were found to describe a connection between stigma and help seeking behavior for depression from the standpoint of potential consumers of mental health services. It is certainly worthwhile and helpful to examine the perceived stigma of those who have received a psychiatric diagnosis; in this way, we are able to understand their situation and intervene. However, stigma is a societal phenomenon, and an understanding of variables related to increased stigmatizing responses is imperative in order to combat this pernicious problem. While the

stigmatization that results from a diagnosis of mental illness may be destructive, the potential effects of not seeking treatment due to stigma are devastating. Moreover, an understanding of how predicted help seeking behavior is influenced by stigma provides at least a starting point in seeking interventions, particularly those aimed at early treatment that would counteract this force. In order to create a database regarding stigma by which hypotheses may be developed and tested, basic groundwork is necessary.

I. Inclusion of Women and Minorities

Questions regarding mental illness stigma and minority and other "out groups" (such as those based on gender and race) have relevance to this study. The sample derived from the primary care setting provided an adequate number of females. The sample was fairly homogenous in terms of racial and ethnic background, mainly comprised of middle class American born Caucasians, reflective of the population of the surrounding community, which is 2% non-Caucasian. The sample from the public health setting increased the racial and ethnic heterogeneity, although this sample was mainly limited to individuals who were in an income bracket low enough to qualify for public assistance.

V. RESULTS

The results of the data analysis are reported in this chapter. The chapter begins with a description of the demographic characteristics of the sample, followed by a description of the results of the study.

A. Sample Characteristics

Participants were patients and family members of patients waiting to be seen in both a suburban primary care facility and in an urban public health clinic. A total of 134 individuals were approached at the two health care facilities and were asked to participate in the study. Of this total, 122 (about 91%) agreed and completed the questionnaires. Accounting for missing data and incomplete questionnaires there were 117 useable surveys. Of these surveys, 96 were derived from the suburban facility, and 21 from the urban clinic.

When reasons were given by subjects who declined to participate in the study, they included not feeling well (ranging from malaise to a broken wrist) and a general distaste for surveys. This distaste was connected to frustration with such things as mail surveys and concern that participation would lead to further solicitation of mailings and products. "Every time I fill those things out, I get all kinds of phone calls." The most common method of declining was simply, "No." Couples tended to respond in kind - if one declined to participate in the study, so did the other. .

Table 1 summarizes the basic demographic characteristics of the sample, and also breaks down these sample characteristics between the urban and suburban settings. Most respondents were female (68%). This percentage reflects the typical gender make-up of the waiting rooms due to a general help seeking receptivity and because mothers more often accompanied their children and family members to health care appointments. Furthermore, men were more likely than were women to decline participation in the study.

Respondents were between the ages of 18 and 80. The mean age was 45 with a standard deviation of 15. Subjects identified themselves as Caucasian (84%), black (15%), and American Indian/Alaskan Native (<1%).

Most respondents were married/cohabitating (57%), followed by single (23%), divorced (18%), and widowed (2%). More than 93% of the sample had completed high school. The majority had finished at least some secondary schooling - almost 20% had completed an associate degree, 21% a bachelor's degree, and nearly 14% reported the completion of graduate degrees. Income levels were comparable to the state's median of \$42,631 (DeNavas-Walt & Cleveland, 2002). The median response in this study was \$30,000-39,999.

Table 2 summarizes the political and religious characteristics of the sample, and also breaks down these characteristics by urban and suburban setting. Subjects were asked to respond to two items related to political leanings – one regarding political affiliation and the other about political orientation. Five respondents left both of these questions unanswered, along with other pieces of missing information, and were eliminated from the study. Of the remaining 117 respondents, most identified their

Table 1
Basic Demographic Data for 117 Participants – Overall and Based on Setting

Variable	Overall		Urban		Suburban	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Sex						
Female	80	68.4	9	42.9	71	74
Male	37	31.6	12	57.1	25	2
Race						
Caucasian	98	83.8	4	19	94	97.9
Black	18	15.4	17	81	1	1
American Indian	1	.8	-	-	1	1
Marital Status						
Single	27	23.1	12	57.1	15	15.6
Married/Cohabiting	67	57.3	7	33.3	60	62.5
Widowed	2	1.7	-	-	2	2.1
Divorced	21	17.9	2	9.6	19	19.8
Education						
Less than high school	7	6.1	3	14.3	4	4.2
High school	46	39.2	18	85.7	92	95.8
Associate degree	23	19.7	3	14.3	20	20.8
Bachelor's	25	21.3	3	14.3	22	22.9
Graduate	16	14	3	14.3	13	13.5
Family Income						
Less than \$10,000	14	12	6	28.6	8	8.9
\$10,000-19,999	12	10.3	3	14.3	9	9.4
\$20,000-29,999	19	16.2	6	28.6	13	13.5
\$30,000-39,999	14	12	2	9.5	12	12.5
\$40,000-49,999	17	14.5	1	4.8	16	16.7
\$50,000-59,999	13	11.1	-	-	13	13.5
\$60,000-74,999	17	14.5	2	10	15	15.6
\$75,000 or over	11	9.4	1	5	10	10.4

Table 2
Political and Religious Data for 117 Participants – Overall and Based on Setting

Variable	Overall		Urban		Suburban	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Political Affiliation						
Strong Republican	16	13.7	1	4.8	15	15.6
Not so strong Republican	15	12.8	1	4.8	14	14.6
Ind., close to Republican	8	6.8	-	-	8	8.3
Independent	6	5.1	2	9.5	4	4.2
Ind., close to Democrat	28	23.9	7	33.3	21	21.9
Not so strong Democrat	18	15.4	1	4.8	17	17.7
Strong Democrat	21	17.9	6	28.6	15	15.6
None reported	5	4.3	3	14.3	2	2.1
Political Orientation						
Extremely conservative	5	4.3	1	4.8	4	4.2
Conservative	25	21.4	3	14.3	22	23
Somewhat conservative	18	15.4	2	9.5	16	17
Moderate	41	35	5	23.8	36	38
Somewhat liberal	17	14.5	5	23.8	12	12
Liberal	6	5.1	3	14.3	3	3
Extremely liberal	-	-	-	-	-	-
None reported	5	4.3	2	9.5	3	3
Religious Tradition						
Christianity	105	89.7	17	81	88	91.7
Buddhism	1	.9	-	-	1	1
None	10	8.5	3	14.3	7	7.3
Othr	1	.9	1	4.8	-	-
Christian Affiliation						
Charismatic and Fund.	26	24.8	6	28.6	20	20.8
Conservative Protestant	28	23.9	7	33.3	21	21.9
Mainline Protestant	28	23.9	3	14.3	25	26
Liberal Protestant	5	4.3	-	-	5	5.2
Catholic	18	15.4	1	4.8	17	17.7
Church Attendance						
Never	17	14.5	4	19	13	13.5
One-two times a year	31	26.5	6	28.6	25	26
Once a month	17	14.5	3	14.3	14	14.6
Weekly	38	32.5	6	28.6	32	33.3
More than weekly	14	12	2	9.5	12	12.5

political affiliation as Democrat (37%), followed by Independent (36%), and Republican (27%). Political orientation was identified as mainly conservative (41%), followed by moderate (nearly 35%), and liberal (nearly 20%). No one identified himself or herself as extremely liberal.

There was little religious diversity in the sample. Most subjects identified themselves as Christian ($n = 105$). The only other religious tradition identified was a qualified "sort of" Buddhism ($n = 1$); the remaining responses were no affiliation ($n = 10$), and an unspecified "other" ($n = 1$). Of those subjects who identified themselves as Christian, 85% were Protestant and the remainder Catholic. Most of the subjects attend church at least once a month (59%).

There were noteworthy differences between the demographic characteristics of the subjects from the urban setting as compared to the suburban setting. The average age for urban subjects was 40 ($SD = 15.6$), and for suburban subjects 46 ($SD = 15.1$). Urban subjects were more likely to be male, Black, and single. In regards to income, 71% of urban subjects had an annual income of less than \$30,000, as compared to 31% of suburban subjects. Subjects from the urban setting were more likely to identify themselves as belonging to a conservative Protestant denomination, whereas suburban subjects were more diverse in their Christian affiliation.

Using the Level of Contact Report, subjects were asked to identify their familiarity with depression. Nearly 97% of the sample described some familiarity with the diagnosis; most (70%) had at least seen a movie about depression, and 41% had worked with a depressed person. Nearly half (47%) of the respondents indicated they had a relative with depression. Almost 30% of the subjects in the study indicate they

have depression, though only 17% believed themselves to be currently depressed. Table 3 presents the frequency and percent of endorsement of familiarity items on the Level of Contact Report. The items are listed in order of least intimate contact to most intimate contact. Also included is a measure of those individuals who, in response to a separate question, indicated that they were currently depressed.

Table 3
*Frequency and Percent of Endorsement of Familiarity Items
on the Level of Contact Report*

Variable	<i>n</i>	%
Familiarity index		
Never observed person with depression	4	3.4
Observed, in passing, person with depression	63	53.8
Watched movie about depression	82	70.1
Watched television documentary about depression	46	39.3
Observed person with depression frequently	41	35
Worked with a person with depression	48	41
Job includes services persons with depression	13	11.1
Provides services to persons with depression	14	12
Family friend has depression	39	33.3
Relative has depression	55	47
Lives with a person who has depression	21	17.9
Has depression	35	29.9
Depressed now	20	17.1

B. Research Results

Research Question One

The first research question: What is the relationship between stigmatizing attitudes regarding depression and professional help seeking attitudes? It was hypothesized that there is an inverse relationship between stigmatizing attitudes and intention to seek help for depressive symptoms. Attitudes were measured individually

based on specific stigmatizing attributions, emotional reactions, and behavioral responses that are related to mental illness; they are categorized into nine factors. Factors include the specific attributions of responsibility and dangerousness; emotional reactions of anger, pity, and fear; and behavioral responses of segregation, coercion, help, and avoidance. Scores were obtained by summing the items that represent each factor and dividing by the number of items. This resulted in a potential range of 1 to 7 with a higher mean score indicating a greater endorsement of the factor. Descriptive analyses of responses on each factor of the Attribution Questionnaire are presented in Table 4, and scores based on gender are listed in Table 5.

Table 4
Overall Attribution Factor Scores (N = 117)

Factor	Mean	SD	Range
Responsibility	3.1	1.2	1-6.3
Dangerousness	2.8	1.4	1-5.7
Fear	2.7	1.2	1-5
Segregation	2.7	1.2	1-7
Avoidance	4.3	1	2-6.3
Anger	2.3	1.2	1-6
Coercion	3.3	1	1-5.7
Pity	5	1.4.	1.7-7
Help	4.9	1.5	1.3-7

The Attitudes Toward Seeking Professional Psychological Help Scale

(ATSPPHS) was developed so that a single score could represent the respondent's core attitude toward seeking professional psychological help (Fischer & Farina, 1995). Low scores indicate a negative attitude toward seeking help and high scores indicate receptivity and acceptance for seeking help from mental health professionals.

Respondents chose from a four point Likert scale that ranged from agree (4) to disagree

Table 5

Attribution Factor Scores by Gender

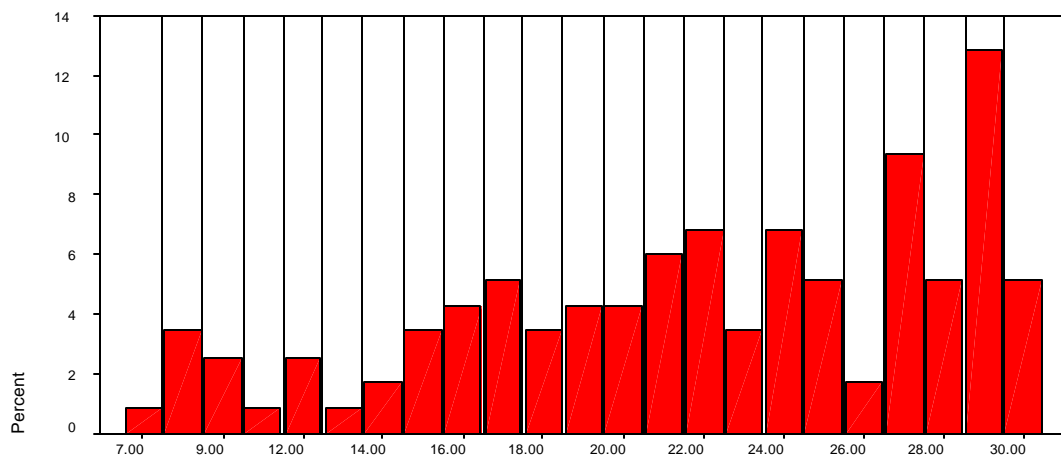
Factor	Male (<i>n</i> = 37)			Female (<i>n</i> = 80)		
	Mean	<i>SD</i>	Range	Mean	<i>SD</i>	Range
Responsibility	3.2	1.1	1-5.7	3.	1.2	1-6.3
Dangerousness	2.8	1.5	1-6	2.8	1.3	1-6.7
Fear	2.0	1.2	1-5	2.2	1.2	1-5
Segregation	3	1.5	1-7	2.6	1.1	1-5.3
Avoidance	4.4	1.1	2-6.3	4.3	1	2-6.3
Anger	2.2	1.1	1-5	2.3	1.2	1-6
Coercion	3.3	1.6	1-5.7	3.3	1.	1-5.3
Pity	4.8	1.4	1.7-7	5	1.3	2-7
Help	4.7	1.6	1.3-7	5	1.5	1.3-7

(1) with no neutral option. For analysis, these responses were recoded on a 3-0 scale to correspond with Fischer and Farina's (1995) original scoring method and to provide comparative scores. Thus, this 10 item scale carried a potential range of total score from 0 to 30. Responses to these items yielded a mean overall score of 21.8 (*SD* = 6.3).

Scores ranged from 7-30 with a mild negative trend (see Figure 1).

Figure 1

*Percent Frequency of Mean Help Seeking Scores (*N* = 117)*



The relationship between stigmatizing attitudes and help seeking attitudes is summarized in Table 6 using Pearson's correlation matrix analyzing bivariate associations. There was a significant inverse relationship ($p < .05$) between the responsibility factor and help seeking, indicating that the less responsible the respondents found the depressed person to be for his or her illness, the more likely the respondents were to endorse help seeking for themselves. Conversely, the more responsible people believed Michael to be, the less likely they were to endorse help seeking for themselves. Most of the respondents (53%) indicated that they did not hold Michael responsible for his illness or were neutral (36%) in this regard; only 11% suggested that Michael was responsible for his illness. Mean help seeking scores listed by subjects' perception of responsibility, from least, to neutral, to most responsible were 23.1, 20.6, and 19.7 ($SDs = 5.9, 5.8, \text{ and } 8.4$, respectively).

Pity, an emotional response related to responsibility attributions, was significantly positively correlated with help seeking. The greater the pity, concern, or sympathy felt for the individual in the case study, the more likely the respondent was to endorse help seeking for depression.

The attribution of dangerousness carried one of the lowest scores of the items in the Attribution Questionnaire. These items included: "I would feel unsafe around Michael," "How dangerous would you feel Michael is?", and "I would feel threatened by Michael." It should be noted that some subjects wondered aloud if the dangerous items referred to threats to others or to Michael himself, generally saying that they wouldn't feel personally threatened, but that he was likely a danger to himself.

When data were analyzed based on the setting in which they were collected, a slightly different picture emerged. While there continued to be a correlation between help seeking and responsibility ($r = .31, p = .01$) in the suburban sample, there was no

Table 6
Pearson's Correlation Matrix of Attribution Items and Overall Help Seeking Score

	1	2	3	4	5	6	7	8	9	10
1. Help seeking	1									
2. Responsibility	-.29**	1								
3. Anger	.03	.39**	1							
4. Dangerous	.01	.22*	.51**	1						
5. Fear	.07	.27**	.54**	.80**	1					
6. Coercion	.08	.12	.43**	.33**	.44**	1				
7. Segregation	.03	.28**	.44**	.53**	.60**	.60**	1			
8. Avoidance	.1	.22	.12	.17	.19*	.03	.17	1		
9. Pity	.19*	.14	.06	.02	.01	.21*	.04	.06	1	
10. Help	.08	.11	.23*	.14	.23*	.09	.09	.16	.44**	1

* $p < 0.05$; ** $p < 0.01$

significant correlation ($r = .12, p = .62$) in the urban sample. One stigmatizing behavior that was significantly correlated to help seeking in the urban sample was that of avoidance ($r = -.45, p < .05$); urban respondents more likely to avoid Michael would be less likely to seek professional psychological help themselves. Overall, people in urban settings had significantly lower avoidance scores ($t = 3.2, p = .002$). The mean avoidance score in the urban setting was 3.7 ($SD = 1.2$), compared to the mean score of 4.5 ($SD = .9$) in the suburban setting.

Research Question Two

What are the relationships between person-level variables (gender, race, political affiliation, religious affiliation, and familiarity with depression) and help seeking attitudes?

Hypothesis 1

Women are more likely than men to endorse help seeking for depression.

The ATTSPPH scale is interpreted so that a higher score indicates greater receptivity toward help seeking. The mean of the overall help seeking score was 21.8 ($SD = 6.3$). Women had a mean help seeking score of 23 ($SD = 5.7$), compared to a help seeking score of 19 for men ($SD = 6.6$). Females had significantly higher help seeking scores ($t = 3.0, p < .005$).

Specific items on the help seeking scale were different when comparing males to females. Women agreed that if they were becoming depressed that their first inclination would be to get professional attention ($t = 2.08, p < .05$). Men endorsed the views that treatment by mental health professionals was a poor way to get rid of depression ($t = 2.65, p < .01$), that the expense outweighed the value ($t = 2.23, p < .05$), people should work out problems for themselves ($t = 4.11, p < .001$), and troubles work themselves out ($t = 2.08, p < .05$).

For both men and women the item most highly endorsed on the professional help seeking scale was "I would want to get professional help if I were depressed for a long period of time." Males chose either *agreed* or *partly agreed* 87% of the time, while females chose either *agreed* or *partly agreed* 90% of the time.

Hypothesis 2

Caucasians are more likely than racial and ethnic minorities to endorse help seeking for depression.

Because of the small numbers of racial and ethnically diverse subjects, race and ethnicity were collapsed into two categories: Caucasian ($n = 98$) and non-Caucasian ($n =$

19). As shown in Table 7, Caucasian subjects had significantly higher help seeking scores than did non-Caucasian subjects ($t = 2.43, p < .05$). Racial comparisons in help seeking attitudes result in no significant differences when Caucasian males are compared to non-Caucasian males ($p = .07$), and Caucasian females to non-Caucasian females ($p = .44$). The setting in which the data were collected influenced overall help-seeking scores, especially with regards to females who scored lower in the urban than in the suburban setting.

Table 7
Mean Help Seeking Scores by Gender, Race, and Setting

	<i>n</i>	Mean	<i>SD</i>	Male			Female		
				<i>n</i>	Mean	<i>SD</i>	<i>n</i>	Mean	<i>SD</i>
Caucasian	98	22.4	6.1	27	20.5	6.4	71	23.1	5.8
Non-Caucasian	19	18.7	6.5	10	16.1	6.6	9	21.6	5.4
Urban Setting	21	18.2	6	12	16.3	6.3	9	20.8	4.6
Suburban Setting	96	22.6	6.1	25	20.1	6.4	71	23.2	5.8

Hypothesis 3

A positive relationship exists between both political and religious liberalism and help seeking for depression.

Help seeking scores for both political affiliation and orientation, and religious conservatism-liberalism are summarized in Table 8. Political affiliation was reduced to three common categories without the qualifiers *strong*, *not so strong*, and *close to*. Likewise, political orientation was reduced to conservative, moderate, and liberal omitting the *extremely* and *somewhat* designations. Those who were Democrat had the highest help seeking scores, followed by Independent, and Republican. Those with moderate and liberal political orientation had scores that were nearly the same; a conservative orientation yielded lower mean help seeking scores.

Table 8

Mean Help Seeking Scores Based on Political and Religious Ideology

Variable	<i>n</i>	Range	Mean	<i>SD</i>
Political Affiliation				
Republican	31	8-30	21.4	6.9
Independent	42	7-30	21.6	6.4
Democrat	39	12-30	22.9	5.5
Political Orientation				
Conservative	48	7-30	21.8	6.2
Moderate	41	8-30	22.3	6.5
Liberal	23	13-30	22.2	5.5
Religious Conservatism/Liberalism				
Charismatic/Fund	26	8-30	19.6	6.5
Conservative Prot	28	8-29	22	6.1
Mainline Prot	28	12-30	24	5.4
Liberal Prot	5	16-30	23	6.1
Catholic	18	15-29	24	4.3

Religious denominations were categorized according to Green's Typology (Green et al., 1996). This typology provides a numeric rating for each Christian denomination on a 1-5 conservative-liberal continuum scale. There was a pattern of increasing help seeking scores as religious affiliation became more liberal. Analysis of variance (ANOVA) demonstrated no significant differences in help seeking scores based on political and religious ideology (see Table 9).

Table 9

Analysis of Variance for Help Seeking and Political and Religious Liberalism

Variable	df	F	η^2	p
Political Affiliation	22	1.4	.81	.14
Political Orientation	21	.70	.44	.82
Religious Orientation	20	.90	1.7	.59

Hypothesis 4

Familiarity with depression, either through personal or significant other experience, is associated with help seeking for depression.

The familiarity score was based on a score that coincided with the most intimate situation endorsed on the 12-item Level of Contact Report (LOC). Overall, familiarity was not significantly correlated ($r = .15, p = .12$) with help seeking, though endorsement of one of the items, "A friend of the family" has depression was significantly correlated with help seeking ($r = .2, p = .03$). Table 10 identifies the mean help seeking scores based on the highest level of familiarity with depression that was indicated on the LOC.

Table 10
Mean Help Seeking Score Based on Highest Choice on Level of Contact Report

Item	<i>n</i>	Mean	<i>SD</i>
Never observed person with depression	1	22	
Observed in passing person with depression	1	9	
Watched a movie with a depressed person	13	21.2	5.7
Watched a documentary about depression	8	19.5	7.7
Observed frequently person with depression	5	19.8	8.
Worked with a depressed person	6	21.5	7.3
Provide services in my job to depressed	1	17	
Job involves treating depressed persons	2	21	0
Friend of the family has depression	9	23.7	6.2
A relative has depression	26	22.7	6.1
Lives with a depressed person	12	22.1	7
Has depression	33	22.2	5.8

The most intimate level of contact with depression on the LOC scale, "I have depression," was in contrast to an additional question that was posed. This question was: "Are you depressed now?" Although there was no significant difference when these items were correlated with help seeking scores, there were trends in scores. For subjects who denied ever having depression, the mean help seeking score was 21.9 ($SD = .7$),

while endorsers had slightly lower mean scores of 21.6 ($SD = 1.1$). In comparison, those who denied being currently depressed had a mean score of 22.3 ($SD = .6$), while those who agreed that they were currently depressed had a score of 19.5 ($SD = 1.5$).

VI. DISCUSSION

As established in the research problem, the purpose of this study was to address the issue of stigmatization of depression from the perspective of the potential consumer. The specific aims were (a) to describe the relationship between stigma and help seeking for depression, and (b) to describe variables that are associated with help seeking attitudes. This understanding would be useful in identifying at-risk populations and developing interventions to promote mental health care. The results of this study are discussed and divided into five sections: findings, limitations, conclusions, implications for nursing, and recommendations for further research.

A. Findings

Stigma and Help Seeking

Compared to psychotic disorders such as schizophrenia, and so-called deviant disorders such as alcoholism or drug abuse, major depression is a mental illness that tends to be stigmatized less (Pescosolido et al., 1999). Results of the current study indicate that people do stigmatize those who have depression, in a way that is similar, but not identical to how other mental illnesses are stigmatized. This study also supports the notion that seeking treatment for depression is complicated and hindered by the problem of stigma, or discrediting negative attributions.

Based on Goffman's theory of stigma and on Attribution Theory it was hypothesized that people who held negative attitudes toward a depressed individual would themselves reject seeking professional psychological help should they perceive the need. The reverse would also hold true, that is, positive attitudes toward a depressed individual would increase the probability of endorsing the seeking of professional psychological help for themselves should they become depressed.

Attitudes were measured individually based on specific stigmatizing attributions, emotional reactions, and behavioral responses that are related to mental illness; they are categorized into nine factors in the Attribution Questionnaire. Factors include the specific attributions of responsibility and dangerousness; emotional reactions of anger, pity, and fear; and behavioral responses of segregation, coercion, help, and avoidance.

Responsibility

Responsibility attributions refer to the degree of control that someone has over being depressed. According to the Attribution Model (Corrigan, Green, et al., 2001), respondents who believe that being depressed is outside of Michael's control (for example, depression is chemically caused) will respond emotionally with pity, and behaviorally with help. If, however, respondents believe that Michael could control the depression (for example, by exerting willpower) they will respond emotionally with anger, resulting in punishing behaviors such as segregation from others and coercion into treatment. Dangerousness attributions are those beliefs regarding dangerousness, violence, or unpredictability. According to the model, respondents who believe that Michael is dangerous will respond emotionally with fear, and behaviorally with avoidance.

The attribution that Michael is responsible for his illness was significantly correlated to whether a person would be likely to endorse help seeking for depression. As in the pilot study, lack of endorsement for the responsibility factor (items including "he's at fault," "he can control it," and "he's responsible") was associated with a greater receptivity to help seeking. Only 11% of respondents indicated that they held Michael responsible for his depression, a percentage better than Crisp's (2001) work where only 20% said that depressed individuals should "pull themselves together."

According to the model, the judgment of responsibility that is ascribed to the mental illness will influence the affective responses of pity or anger. There was a nonsignificant relationship between responsibility and pity, though there was a directional tendency for people who think Michael is responsible for being depressed to express less pity. Pity was significantly correlated with help seeking, with the more pity the respondent felt toward Michael, the more likely they were to endorse help seeking for themselves. Consistent with the attribution model, there was a significant correlation between feeling pity for the depressed person and the desire to help the individual who is depressed.

Again, the findings in this study are consistent with the attribution model concerning responsibility and anger. Responsibility beliefs were significantly associated with anger, with judgments that Michael is responsible for his illness being associated with higher levels of anger. These higher levels of anger in turn were correlated with the behavioral responses of segregation and coercion.

Dangerousness

In the present study, help seeking was unrelated to how dangerous people viewed Michael to be. In fact, most respondents (88%) did not consider Michael to be dangerous, and this factor had one of the lowest means of the nine factors being measured on the Attribution Questionnaire with only the mean scores for anger, fear, and segregation being lower.

The attribution model posits that if people believe that someone is dangerous, they respond emotionally with fear, and behaviorally with avoidance. In keeping with this model, the present study demonstrated a significant relationship between dangerousness and fear, and between fear and avoidance. This indicates that if people did consider Michael to be dangerous, they would fear him, and if they feared him, they would avoid him. As noted previously in regards to the attribution of dangerousness, neither the stigmatizing affective response of fear, nor the concomitant behavioral reaction of avoidance was directly related to help seeking intention.

Previous studies using the Attribution Questionnaire have tended to focus on psychotic disorders, where dangerousness is more frequently associated by the public (Corrigan et al., in press). However, only 33% of Americans believe that those with major depression are likely to be violent, whereas 61% believe that people with schizophrenia are likely to do something violent to others (Pescosolido et al., 1999).

Influence of Gender on Stigma and Help Seeking

Gender mediated the connection between stigma and help seeking. Overall, mean scores indicated men held Michael more responsible for his condition than did women. However, there was no correlation between how much responsibility men

believed Michael had for his depression and whether they themselves would agree to seek help for depression. Intellectually, men, along with most Americans, accept that depression results from a combination of stress, chemical imbalances, and genetics (National Opinion Research Center, 1996). If men understand the physical origins of depression, and that it is therefore treatable, then why doesn't that translate into them seeking help for depression?

Interestingly, for men help seeking was most strongly associated with feeling pity for the depressed person ($r = .65, p < .01$). How does feeling pity for a depressed person become more important for men than simply understanding depression? It is possible that in order for men to find help seeking to be acceptable for them or to feel for a depressed person, it is essential to move beyond merely intellectual understanding of major depression. This understanding must translate to the affective dimension where men could feel empathy. Further gender-based research, especially one with qualitative and quantitative aspects would be useful in the examination of the connection between intellectual and emotional responses in predicting intention to seek help for depression.

Influence of Setting on Stigma and Help Seeking

There were notable differences between the responses of individuals from the urban setting as compared to the suburban setting. Overall, responsibility attributions are significant if a person is to seek help for depression; however, this was not the case for the urban respondents. For them responsibility was not associated with help seeking tendency, though the behavioral response of avoidance was important. As compared to suburban respondents, urban respondents were more likely to endorse avoidance and separating themselves from the depressed person. This avoidance is in keeping with

Goffman's (1963) theory that we respond to stigmatized individuals with aversion. This aversion decreases the possibility of help seeking, since to seek help for depression decreases the distinctions and differentness, and puts them in jeopardy of being discredited.

The different responses to depression and help seeking between subjects in one facility as compared to the other is intriguing. These differences cannot be attributed only to the setting because of the demographic make-up of the two groups. Most respondents in the urban facility were male, black, single, had a high school education or less, and an income under \$30,000 a year. In contrast, most of the suburban facility respondents were female, Caucasian, married, had some college education, and had incomes over \$40,000 a year. Any comparison of the differences found in this study would have to take those variables into account.

Person-Level Variables and Help Seeking

In addition to determining how stigma influences help seeking attitudes, the question of whether there are specific individual characteristics that influence help seeking attitudes is interrelated. Though stigma is closely connected to an overall societal phenomenon, there are person-level variables that were found to exert an influence (positively or negatively) on whether an individual would choose to seek treatment for depression.

Female and Male Help Seeking

As expected, the examination of gender differences indicated that female subjects were significantly more likely to endorse professional help seeking than were males. Specific items from the Attitudes Toward Seeking Professional Psychological Help Scale

(ATSPPHS) were significantly correlated with gender. Specific items were endorsed by significantly more males: the belief that personal and emotional troubles tend to work out by themselves, getting professional help for problems would be a last resort, and that professional help would have doubtful value when considering the time and expense. The theme emerged among male respondents that professional help for depression is not only unnecessary, but a waste of time and money.

A comparison of attribution scores in the current study reveals few significant differences in the way men as opposed to women responded in terms of stigmatization to a depressed person. Interestingly, and perhaps, optimistically, most men indicated that they would seek help if they were depressed for a long period of time. If men express a willingness to seek help if they are depressed for a long period of time, then what is it that prevents men from seeking help? One possible explanation is that men do not identify their symptoms as depression, but rather believe themselves to be experiencing "problems" that can work out by themselves, rendering help seeking a waste of time.

Perhaps it is not attitude that is limiting men's pursuit of mental health care, but rather emotional self-knowledge and recognition of how it feels to have symptoms of major depression. This lack of self-understanding may be made worse by denial. Previous studies have indicated that men do not recognize the need for help (Leong & Zachar's, 1999) and the current study supports this notion. Furthermore, men tend to minimize the emotional consequences of stressful life experiences, while women "experience" their experiences and acknowledge the feelings more easily (Sherrill et al., 1997). Finally, men agreeing to seek help only if they were depressed "for a long period of time" is similar to waiting for the symptoms to get critical before going to the

emergency room for a heart attack. Even if delays in seeking help do not result in mortality, these delays result in a lengthened period of non-productivity, impaired relationships, and decreased quality of life.

Caucasian and Non-Caucasian Help Seeking

Caucasians were more likely to seek help for depression and there was a significant difference in scores between Caucasians and non-Caucasians. This result is consistent with other studies. However, this result is mediated when the influence of gender is factored into the equation. More than half of non-Caucasians were male (53%), as compared to slightly more than a quarter of Caucasians who were male (28%). As mentioned previously, gender was significantly related to help seeking intention, and males are less likely to endorse help seeking. Racial comparisons in help seeking attitudes result in no significant differences when Caucasian males are compared to non-Caucasian males, and when Caucasian females are compared to non-Caucasian females.

When the items of the ATSPPHS were compared separately, two questions were responded to differently based on race and accounting for gender. One was, "The idea of treatment by a mental health professional strikes me as a poor way to get rid of depression," and the other, "A person should work out his or her own problems; getting professional help would be a last resort." Caucasian males tended to disagree with those statements, while non-Caucasian males were inclined to agree with those statements. Though the number of non-Caucasian males in the sample is small, based on this study and on prior literature, there is reason to believe that they are placed in a position of dual-risk in regards to help seeking for depression.

Political and Religious Liberalism and Help Seeking

There was no statistical significance to support the hypothesis that liberalism increases help seeking. However, there is directional support (help seeking means increased as people became more liberal) that both political and religious liberalism increases the likelihood of endorsement for seeking treatment for depression.

Race had a mediating influence on help seeking and religious affiliation. Among Caucasians there was a significant positive correlation between help seeking and a liberal religious affiliation. Among non-Caucasians there was no significant correlation between help seeking and religious affiliation. Non-Caucasians in this sample identified themselves as either religiously conservative or as having no religious affiliation, and nearly all of them identified their political affiliation as Democrat or Independent, an identification that is consistent with the general minority population.

Familiarity and Help Seeking

Surprisingly, there was no significant correlation between familiarity with depression based on the Level of Contact Report and help seeking attitudes as measured by the ATSPPHS. The Level of Contact Report (Holmes et al., 1999), assesses familiarity based on the amount and degree of contact the research participant has had with depression. Respondents received a score of 1-12 based on the greatest level of contact with a depressed individual. These results indicate that being familiar with depression is not enough to increase the likelihood of seeking help.

Though the Level of Contact Report score was not significantly correlated with help seeking, a specific item on the measure was. Help seeking was correlated with "A friend of the family has depression." This item is the fourth highest in terms of intimacy, lower than: "I have depression," "I live with a person who has depression," and "I have a

relative who has depression." If having a friend with depression is associated with a higher endorsement for help seeking, there may be several reasons. Friendship, as opposed to the other three more intimate items on the Level of Contact Report, may indicate a choice as well as an acceptance of the person along with his or her diagnosis.

While people can perhaps accept depression in their friendships, they do not want depression too close to home. A previous study (Martin, Pescosolido, & Tuch, 2000) found that 23% of people studied were unwilling to make friends with depressed individuals, while 61% did not want people with depression to marry into their families. People are least willing to accept people with any kind of mental health problem as coworkers or family members (National Opinion Research Center, 1996).

Having depression or being related to someone with depression are not choices that people make. Depression is frustrating in its capacity to impair both physical functioning and interpersonal relationships, and people often continue to suffer from relapses or depressive symptoms despite treatment. According to Bayer and Peay (1997) in order for people to value help seeking, they need to believe that mental health professionals can actually help. It is possible that being intimately connected with depression beyond a friendship may create an aversion to treatment in some situations or despair over its efficacy.

Respondents made a distinction between a familiarity item that read, "I have depression" and an additional question that asked, "Are you depressed now?" Nearly 30% indicated they had depression, while only 17% reported they were currently depressed. The difference in response may be interpreted to mean that the former refers to having been diagnosed with depression at one time or perceiving themselves to have

been depressed previously, while the latter was interpreted as meaning a current acute depression. Interestingly, help seeking scores varied between the two groups. Those who agreed with "I have depression," were more likely to endorse help seeking for depression than were those who agreed with "I am depressed now." This difference may be due to the negativity that accompanies depression; respondents agree they are depressed, but nothing can help. Additionally, this low help seeking score may indicate that depressed people are depressed because they have found treatment to be ineffective or not worthwhile, or because they avoid treatment entirely.

Familiarity was found to mediate stigmatizing attributions regarding depression. In accordance with both stigma and attribution theory, familiarity with individuals who possess a stigmatized condition is related to a decreased tendency to stigmatize. Other studies have supported this theoretical premise. In descending order, the attitudes most positively influenced by familiarity were segregation, fear, coercion, avoidance, responsibility, and dangerousness.

There seems to be an indirect connection between familiarity and help seeking; familiarity may impact help seeking by mediating responsibility beliefs. As discussed in the first research question, the attribution of responsibility was significantly correlated with help seeking. In order for people to agree with getting help for depression, they need to believe that depression is not under personal control and treatable like other medical conditions. There is a significant correlation between familiarity and responsibility ($r = .23, p < .05$). It may be that as familiarity with depression increases, responsibility beliefs (or blame for the condition) decrease, thereby increasing the chances for seeking treatment for depression. Worthy of further investigation in regards

to familiarity and help seeking is the connection between familiarity and whether the depressed person was responsible for his condition or not.

Other Person-Level Variables

It was noted that the older people get, the more willing they are to seek help – up to a point. Mean help seeking scores increased with each decade until age 60. For ages 18-59 there is a relationship between age and help seeking ($r = .37, p < .01$). This acceptance may be due to a general maturation and acceptance of depression as something that they have seen happen before, or perhaps they have experienced it themselves. It is possible that there is a generational demarcation that separates the over-age-60's from the rest. This age group consists of people who were born before the 1950's and the advent of psychotropic drugs, whose early adult years were influenced by large-scale institutionalization, and who came along a little late to embrace the introduction of efficient and effective antidepressants such as the selective serotonin reuptake inhibitors. Research has demonstrated that the elderly population is at the highest risk for suicide, especially elderly males. It is not surprising to have encountered individuals with negative attitudes toward help seeking in primary care settings since studies have shown that 70% of elderly people were in contact with primary care providers within a month of their suicides, but not with mental health professionals (Hyman, 2000).

B. Limitations

Results of the study can be generalized only to the population of patients presenting for services at the primary care facility or the health department, and then

agreeing to take part in the study. The sample was limited to people who had already made a decision to seek healthcare, implying that they were at least motivated to seek some sort of help from the healthcare system. The sample didn't include those people who are presumably at the most risk - namely, the ones who don't seek help for any reason.

It is also important to consider that individuals who completed the questionnaires may have been different from those who did not. Individuals who declined to participate in the study were more often male, blue-collar, and middle-aged. In couples, people tended to respond in kind – if one person declined to participate, then so did the other. Clearly understanding stigmatizing and help seeking attitudes from these non-respondents is as valuable as the information gained from those who agreed to participate.

The investigator introduced herself to potential subjects and explained that she was a registered nurse conducting a study on depression. Their responses may have been influenced by the fact that the investigator was a registered nurse since the subjects were present to receive healthcare from nurses and physicians. Their responses may have been influenced by a power differential, or the desire to respond in a socially acceptable or expected manner.

There were insufficient numbers of non-Caucasians to provide an accurate representation of stigmatizing and help seeking attitudes in other racial/ethnic groups. The percentage of African Americans in the sample actually exceeded the area in which the study was conducted, and in the United States (U.S. Census Bureau, 2001), however generalizations are compromised by the settings from which the subjects were drawn.

Nearly all the non-Caucasians in the study came from an urban public health center. When variables that are being studied are different between Caucasians and non-Caucasians, it is impossible to determine if the differences are due to race or from socioeconomic considerations. Other racial groups such as Asians and those with Hispanic Origins were completely absent from the sample.

A disadvantage of written questionnaires is the inability to readily clarify questions. Personal interviews would have helped to individuals understand what they were being asked. Furthermore a verbal interview would have permitted those individuals (eg., examples include those who are illiterate, the blind, and very elderly individuals) who could not complete a questionnaire to participate.

The use of a male in the vignette about the depressed person may have influenced the responses. It is possible that subjects would have responded differently to a clinically depressed female, both in terms of stigmatization (especially in regards to dangerousness) and in slanting their own responses to seeking help.

Some of the questions on the Attribution Questionnaire are more applicable to psychiatric illnesses that include a component of violence often associated with alcohol or drug abuse, or the unpredictability that is associated with the disordered thought accompanying schizophrenia. Though depression may be accompanied by agitation or even with psychosis, these symptoms are generally associated with depression by the general public. The Attribution Questionnaire contained items that may be more or less applicable to depression. Respondents tended to agree with two of three items that made up the coercion factor: "I would require Michael to take his medication," and "Michael should be forced into treatment with his doctor," but rejected the third, "I would force

him to live in a group home." This indicates that attributions to mental illness vary depending on the illnesses' perceived severity.

The attribution model identifies dangerousness as a base attribution for the stigmatization of mental illness. In regards to the dangerousness question - "How dangerous would you feel Michael is?" - several subjects asked if this dangerousness referred to Michael or to others. Based on the comments of subjects who asked, the consensus was that he was not a danger to others, but certainly to himself. This anecdotal evidence is consistent with Pescosolido et al. (1999) study in which those with depression were viewed by 33% as a threat to others and by 75% as a threat to themselves. In contrast, 61% identified those with schizophrenia as a threat to themselves, and 92% as a threat to others.

C. Conclusions

Major depression is a mental illness that most everyone is touched by and knows about. Still, depression is considered to be a stigmatizing condition, only less stigmatized than schizophrenia and alcohol/substance abuse. People do not feel neutrally when it comes to responding to those who have depression or putting forth explanations as to why it occurs. The decision to seek help for depression is influenced by a variety of factors, some of which were touched upon in this study.

The clearest conclusion in regards to stigmatizing attributions and their influence on help seeking attitudes is that the issue of controllability is inextricable from the issue of stigmatization. People are less inclined to seek help if they believe depression is within personal control, and are more likely to disparage those who are depressed. The

National Opinion Research Center (1996) concluded that as compared to other severe mental illness, people believe depression is more likely to improve on its own, is more often caused by the social environment, and is less chemically (psychobiologically) controlled. The current study calls attention to the significance of these beliefs. Why seek help if the problem will go away on its own? In fact, people who believe that depression is subject to personal control, a matter of willpower or spiritual strength, are more likely to feel anger towards those who are depressed and say they wouldn't themselves seek help for depression. People who believe that depression is not under personal control, and that it is a medical illness like any other, feel greater pity for those who are depressed, desire to help, and have a greater tendency to seek help themselves.

Gender was shown to be an important variable in the prediction of help seeking attitudes and this conclusion has been demonstrated in previous studies as well. Females in this study were significantly more likely to endorse help seeking. Race was also correlated with help seeking, with Caucasians more likely to endorse help seeking for depression. In this study, the greater proportion of males to females in the non-Caucasian group may limit the generalizability of this finding. A relationship between political/religious liberalism/conservatism and help seeking was not established in this study, though there is directional support to warrant further investigation.

Familiarity with depression at the most intimate level as measured by the Level of Contact Report – having had it or having a relative with depression was not associated with a greater receptivity to help seeking, but having a friend with the diagnosis was. This indicates that there may be other variables that mediate the benefit of familiarity on help seeking for depression, such as personal conflict with the depressed person or

disenchantment with mental health care. People who identify themselves as being currently depressed had relatively low help seeking scores, creating the paradox of depression possibly being a person-level variable that impedes help seeking for depression.

D. Implications for Nursing Practice

The pilot study on which the current study is based demonstrated that nursing students had an overall higher opinion of seeking help than did the subjects in this study. This finding is reason for optimism. Their perception of mental illness is important in terms of potential political and social influence, in their responses to patients with mental health alterations, and as potential consumers. When asked why they have chosen to pursue nursing as a career, students nearly all state that they want to care for others. Boughn and Lentini (1999) support this notion, adding that students have an interest in empowering both their patients and themselves. However, in regards to caring for those with mental illness, this wish to care for and empower others is mitigated by the overall prejudices and stereotypes of society. Students hold the same misconceptions and negative attitudes (Rushworth & Happell, 1998).

Nurse educators should become self-conscious models and avoid stigmatizing characterizations of those with mental illness in all clinical settings. Nursing faculty contribute to this problem by not fully valuing the learning that occurs in the psychiatric rotation (Oermann & Sperling, 1999). Psychiatric/mental health nurse educators can take the lead by viewing the Surgeon General's imperative to address stigma (Satcher, 1999)

as an invitation to develop education strategies to dispel prejudices and stereotypes before nurses enter their careers.

No matter the field, virtually every nurse will come across major depression, a common and potentially life-threatening illness. Because nurses are often in a frontline position, one that places them into closer and longer contact with patients and clients, their influence in changing stigmatizing attributions, particularly those that blame the depressed person for being ill, is noteworthy. Furthermore, the profession of nursing supports holistic and preventative care. In regards to depression, this care can include teaching depression's basic pathophysiology, signs and symptoms, and the identification of options for help.

Screening for depression by nurses and physicians in primary care settings and in acute care settings such as the hospital is a valuable part of every basic assessment. Nurses routinely utilize scales to identify those individuals who are at risk of developing bed sores as they are admitted to the hospital. Simple screening procedures, particularly of those individuals who are at greatest risk could reduce the mortality rate, the cost, and discomfort that depression directly and indirectly brings about. If depressive symptoms and depression were diagnosed by the first line in the health care team, steps could be taken to secure treatment or to make referrals to mental health specialists. Depression should be considered despite the presenting problem since many people who are depressed will more readily seek help for somatic complaints than for mental distress (O'Connor, Sheehy, & O'Connor, 1999). Of particular importance in regards to screening for depression are the elderly, especially elderly males who often seek primary care, but rarely mental health care (Hyman, 2000). Psychiatric nurses can take an active role in

identifying at-risk populations, especially males and minorities, and provide teaching that would help to ameliorate myths regarding depression.

E. Recommendations

Research indicates that the magnitude of stigmatization of mental illness is based on the specific illness (National Opinion Research Center, 1996), and those that are deemed more dangerous and unpredictable are most highly stigmatized. However, various mental illnesses elicit not just a difference in amount of response, but also different responses. Qualitative studies could shed light on the how people experience and respond to depression in others, as well as gain a deeper understanding of attitudes toward help seeking. This sort of research could prove to be valuable in providing direction for future work.

Further examination of the stigmatization of depression and its relationship to help seeking could be accomplished by adapting the Attribution Questionnaire to relate more specifically to those attributes that are most associated with depression. Qualitative research could serve as a basis for identifying these attributes. Future studies should include a specific measure of stability of depression, or how likely people believe depression is responsive to treatment, a belief that is related to controllability. Comparing stigmatizing attitudes with actual measures of service use could augment findings from this study.

Research findings support the need for a greater understanding of vulnerable populations, including males. Historically, studies of depression have made use of the most available subjects, namely women, for this is the group that was more frequently in

treatment, identifiable, and available for study. The male experience of depression could be better understood through more qualitative work, thereby providing both practitioners and consumers with tools to identify symptoms that are male-specific. Outcome based intervention studies can help men identify the difference between feeling blue and feeling depressed, and to know when help seeking is necessary. Also in regards to feelings and gender, examination of the connection between intellectual and emotional responses in predicting intention to seek help for depression could be beneficial in developing stigma-changing strategies.

Future studies should attempt to identify non-respondents. Characteristics of those who declined to participate could add to our knowledge of stigma and help seeking for depression. Males declined to participate in the study more often than did females (this was troubling considering the proportion of males to females in the first place). However, there is reason for optimism regarding this group of men since they were at least in a healthcare waiting room - if not for themselves, then for someone else. The potential for diagnosis and treatment of any illness is increased by this presence.

Despite literature that describes minorities as being less compliant with the dominant system, all non-Caucasians, both males and females, who were approached agreed to participate in this study. This agreement is encouraging as future researchers seek to understand the minority experience of depression. Previous research has demonstrated that minority groups are more affected by stigma and that members of minority groups are more likely to take keep their problems to themselves or within the family. Males in minority groups are placed in a double jeopardy and may be at a higher

risk. Further studies regarding stigma and help seeking should include increased numbers of minority subjects from a wider range of socioeconomic backgrounds.

This study indicates that minority groups are less likely to seek professional psychological help for depression. The literature indicates that among minorities it is especially important to include significant others in the treatment of mental illness; studies that encompass the family system would provide a greater understanding of how significant others exert influence on family members. An indirect method of intervening that is worthy of exploration may be to teach the most receptive segments of minority groups (e.g., females and health care professionals) assessment and referral skills which could be used within the community.

Finally, there is a group of individuals who are conspicuously absent from this sample, namely, those who don't seek healthcare. The findings in this study can be generalized only to those who have decided to seek help for some problem. Research on stigma and help seeking for depression should be undertaken in settings outside of the healthcare system and with a sample that is not made up entirely of help seekers and/or their companions.

F. Summary

Much of the research regarding the stigma for mental illness is focused on the most vulnerable populations, especially those who have schizophrenia. These individuals are subject to a wide-range of stigmatizing attributions, and issues of help seeking that are complicated by impaired thought processes and objectionable side effects from medications. While it is evident that society does not hold stigmatizing attributions for

depression to the same degree as it does schizophrenia, there is still the perception that depression is a sign of weakness or evidence of a flaw. People are needlessly suffering from depression and even ending their lives due to this illness and effective treatments are being wasted.

There is reason for optimism that the burden of shame for depression may be reduced as the mystery of genetics are unraveled, neurochemistry is understood, and new treatments are developed. There is also an increased national focus on mental illness and stigma. This focus began with the Surgeon General's 1999 Report on Mental Health, and continued through an April 2002 presidential appointment of a national commission to make recommendations for the future of mental health care in the United States. These recommendations should gain the attention of policy makers who are in the position to direct resources into mental health care. Misperceptions regarding depression and options for its treatment can limit the effectiveness of even the most progressive programs if people who are in need are not making appropriate use of them. The increased national attention makes this an opportune time to study and develop interventions to combat stigma and promote appropriate help seeking for depression.

APPENDIXES

Appendix A

Demographic Data Form

Gender: ? Male ? Female Age: _____

Marital Status: ? Single ? Married/Cohabiting ? Widowed ? Divorced

Hispanic Origin and Race:

Are you Spanish/Hispanic/Latino? ? Yes ? No

What is your race? Check one or more races that you consider yourself to be:

? White ? Black, African American

? American Indian or Alaska Native

? Asian Indian ? Japanese ? Native Hawaiian

? Chinese ? Korean ? Guamanian or Chamorro

? Filipino ? Vietnamese ? Samoan

? Other Asian _____ ? Other Pacific Islander

? Some other race _____

Education:

What is the highest grade in elementary school or high school that you finished and got credit for? _____

Did you complete one or more years of college for credit?

? Associate/Junior college

? Bachelor's

? Graduate

Political affiliation:

? Strong Republican

? Not so strong Republican

? Independent, close to Republican

? Independent, other party

? Independent, close to Democrat

? Not so strong Democrat

? Strong Democrat

Orientation to political issues:

- ? Extremely conservative
- ? Conservative
- ? Somewhat conservative
- ? Moderate, middle of the road
- ? Somewhat liberal
- ? Liberal
- ? Extremely liberal

Family income:

- | | |
|----------------------|--------------------|
| ? Less than \$10,000 | ? \$40,000-49,999 |
| ? \$10,000-19,999 | ? \$50,000-59,999 |
| ? \$20,000-29,999 | ? \$60,000-74,999 |
| ? \$30,000-39,999 | ? \$75,000 or over |

Religious affiliation:

Which best describes your religious tradition:

- ? Christianity ? Judaism ? Islam ? Buddhism ? Hinduism ? None
- ? Other _____

If you are currently of the Christian faith, how would you describe your affiliation?

- | | |
|--|------------------------------------|
| ? Adventist | ? Holiness |
| ? Assemblies of God | ? Lutheran |
| ? Baptist: Bible and Independent | ? Lutheran: Missouri and Wisconsin |
| ? Baptist: Southern, American, and Black | ? Mennonite |
| ? Christian and Missionary Alliance | ? Methodist: Free |
| ? Christian Church | ? Methodist |
| ? Christian Reformed Church | ? Nazarene |
| ? Christian Scientists | ? Orthodox |
| ? Church of Christ | ? Pentecostal |
| ? Church of God | ? Presbyterian |
| ? Congregationalist | ? Quaker |
| ? Disciples of Christ | ? Reformed |
| ? Episcopalian | ? Roman Catholic |

? Evangelical Free/Evangelical Covenant ? Other _____

How often do you attend church?

? Never ? 1-2 times a year ? Once a month ? Weekly ? More than once a week

Familiarity with Depression

Place a check by the true statements.

___ I have watched a movie or television show in which a character depicted a person with depression.

___ My job involves providing services/treatment for persons with depression.

___ I have observed, in passing, a person I believe may have depression.

___ I have observed persons with depression on a frequent basis.

___ I have depression.

___ I have worked with a person who had depression at my place of employment.

___ I have never observed a person that I was aware had depression.

___ My job includes providing services to persons with depression.

___ A friend of the family has depression.

___ I have a relative who has depression.

___ I have watched a documentary on the television about depression.

___ I live with a person who has depression.

Are you depressed now?

? Yes ? No

Appendix B

Attribution Questionnaire

Your neighbor, Michael, is a 30 year-old man who was hospitalized for a gunshot wound from a suicide attempt. He works as a clerk at a large law firm. He looks sad, cries easily, lacks motivation, and has difficulty concentrating. Michael reports sleeping four hours at night and constantly fatigue. He has little interest in food and has lost 10 pounds in the past month.

Michael has quit going to church and thinks that God has abandoned him. He has no significant other, and his family is out of the area. Michael doesn't see any reason to remain in the hospital, and believes that "everyone would be better off" if he were dead. He has had six hospitalizations for depression.

Answer each of the following questions about Michael. Circle the number of the best answer to each question.

1. I would feel aggravated by Michael.

1	2	3	4	5	6	7
not at all					very much	
2. I would feel unsafe around Michael.

1	2	3	4	5	6	7
no, not at all					yes, very much	
3. Michael would terrify me.

1	2	3	4	5	6	7
not at all					very much	
4. How angry would you feel at Michael?

1	2	3	4	5	6	7
not at all					very much	
5. If I were in charge of Michael's treatment, I would require him to take his medication.

1	2	3	4	5	6	7
not at all					very much	
6. I think Michael poses a risk to his neighbors unless he is hospitalized.

1	2	3	4	5	6	7
none at all					very much	
7. If I were an employer, I would interview Michael for a job.

1	2	3	4	5	6	7
not likely					very likely	

8. I would be willing to talk to Michael about his problems.
- | | | | | | | |
|------------|---|---|---|-----------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not at all | | | | very much | | |
9. I would feel pity for Michael.
- | | | | | | | |
|-------------|---|---|---|-----------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| none at all | | | | very much | | |
10. I would think that it was Michael's own fault that he is in the present condition.
- | | | | | | | |
|----------------|---|---|---|--------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| no, not at all | | | | yes, absolutely so | | |
11. How controllable, do you think, is the cause of Michael's present condition?
- | | | | | | | |
|------------------|---|---|---|------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not at all under | | | | completely under | | |
| personal control | | | | personal control | | |
12. How irritated would you feel by Michael?
- | | | | | | | |
|------------|---|---|---|-----------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not at all | | | | very much | | |
13. How dangerous would you feel Michael is?
- | | | | | | | |
|------------|---|---|---|-----------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not at all | | | | very much | | |
14. How much do you agree that Michael should be forced into treatment with his doctor even if he does not want to?
- | | | | | | | |
|------------|---|---|---|-----------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not at all | | | | very much | | |
15. I think it would be best for Michael's community if he were put away in a psychiatric hospital.
- | | | | | | | |
|------------|---|---|---|-----------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not at all | | | | very much | | |
16. I would share a car pool with Michael every day.
- | | | | | | | | |
|------------|---|---|---|------------------|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| not likely | | | | very much likely | | | |
17. How much do you think a psychiatric unit, where Michael can be kept away from his neighbors, is the best place for him?
- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|

not at all very much

18. I would feel threatened by Michael.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

no, not at all yes, very much

19. How scared of Michael would you feel?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

not at all very much

20. How likely is it that you would try to help Michael?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

definitely would not help definitely would help

21. How certain would you feel that you would help Michael?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

not at all certain absolutely certain

22. How much sympathy would you feel for Michael?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

none at all very much

23. How responsible, do you think, is Michael for his present condition?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

not at all responsible very much responsible

24. How frightened of Michael would you feel?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

not at all very much

25. If I were in charge of Michael's treatment, I would force him to live in a group home.

1 2 3 4 5 6 7

not at all very much

26. If I were a landlord, I probably would rent an apartment to Michael.

1 2 3 4 5 6 7

not likely very likely

27. How much concern would you feel for Michael?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

none at all very much

Appendix C

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)

Circle the number of the best answer to each question.

1. If I believed I was becoming depressed, my first inclination would be to get professional attention.

1	2	3	4
	partly	partly	
agree	agree	disagree	disagree

2. The idea of treatment by mental health professional strikes me as a poor way to get rid of depression.

1	2	3	4
	partly	partly	
agree	agree	disagree	disagree

3. If I were experiencing serious depression at this point in my life, I would be confident that I could find relief in professional help.

1	2	3	4
	partly	partly	
agree	agree	disagree	disagree

4. There is something admirable in the attitude of a person who is willing to cope with depression *without* resorting to professional help.

1	2	3	4
	partly	partly	
agree	agree	disagree	disagree

5. I would want to get professional help if I were depressed for a long period of time.

1	2	3	4
	partly	partly	
agree	agree	disagree	disagree

6. I might want to have professional counseling in the future.

1	2	3	4
	partly	partly	
agree	agree	disagree	disagree

7. A person with depression is not likely to get better alone; he or she is likely to get better with professional help.

1	2	3	4
agree	partly agree	partly disagree	disagree

8. Considering the time and expense involved in professional help, it would have doubtful value for a person like me.

1	2	3	4
agree	partly agree	partly disagree	disagree

9. A person should work out his or her own problems; getting professional help would be a last resort.

1	2	3	4
agree	partly agree	partly disagree	disagree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

1	2	3	4
agree	partly agree	partly disagree	disagree



SCHOOL OF NURSING
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Appendix D

Consent Form

DUQUESNE UNIVERSITY

COLLEGE HALL • PITTSBURGH, PA • 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE:	The influence of stigma on help seeking attitudes for depression
INVESTIGATOR:	Margaret Jordan Halter, doctoral student, Duquesne University, Pittsburgh, PA Associate Professor of Nursing, Malone College, Canton, OH 44709 (330) 471-8163
ADVISOR:	L. Kathleen Sekula, PhD School of Nursing, Duquesne University, Pittsburgh, PA 15282 (412) 396-4865
Latest IRB Review: July 2002 (Duquesne University)	

This study is being performed as partial fulfillment of the requirements for the doctoral degree in nursing at Duquesne University. Before you decide to take part, please ask any questions that you might have.

PURPOSE OF THIS STUDY:

The purpose of this study is: (1) to describe a relationship between beliefs about depression and help seeking attitudes for this problem, and (2) to describe a relationship between variables (sex, race/culture, political affiliation, religious affiliation, and familiarity with depression) and help seeking intention.

PROCEDURES FOR THIS STUDY:

If you choose to participate in this study, you will be asked to complete three forms: a general demographic data form, questions concerning your beliefs about depression, and your thoughts on seeking professional psychological help. This should take approximately 10 minutes.

RISKS AND BENEFITS:

There are no known benefits to participating in this study. The potential risk of participating in this study is that it may produce anxiety as you examine your own beliefs. Should you wish to speak to someone confidentially about the issue of depression your physician is available.

COMPENSATION:

This study will not involve any costs to you. You will not receive payment for participation in the study.

CONFIDENTIALITY:

Your name will never appear on any survey or research instruments. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's office. Your responses will only appear in statistical data summaries. All materials will be destroyed after five years.

RIGHT TO WITHDRAW:

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

COMPENSATION FOR ILLNESS OR INJURY:

In the event of an injury or illness resulting from the research procedures no monetary compensation will be made by Duquesne University.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412) 396-6326.

Participant's Signature

Date

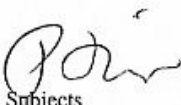
Researcher's Signature

Date



Duquesne University
Institutional Review Board
MEMORANDUM

To: Margaret Halter

From: Paul Richer, Ph.D. 
Chair, IRB - Human Subjects
403 Administration Building

Re: Proposal #02/47 - "The influence of stigma on help seeking attitudes for depression"

Date: August 6, 2002

Thank you for submitting your proposal and revisions to the Duquesne IRB.

Based upon the recommendation of IRB member, Dr. Pat Fedorka, and my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule governing ethics in research with human subjects. The intended research, involving survey procedures, poses no greater than minimal risk to human subjects. Therefore, under rule 46.101, your proposed research is hereby **approved** on an **expedited** basis.

Please remember to print the first page of your consent forms on Duquesne letterhead and to make two copies with original signatures, one for the participant and one for you.

You will be required to submit an annual report updating the IRB regarding the status of your research. In addition, any changes in the procedures involving human subjects or any adverse effects on human subjects prior to the annual review must be brought to our attention immediately. The IRB reserves the right to suspend or terminate the study if it is not conducted in accordance with the approved protocol and conditions as described above, or if any unexpected, adverse effects arise.

Once your study is complete, please provide the Board with a copy of the study results at the address shown above.

Best wishes for your study and thank you for contributing to Duquesne's research efforts.

C: Kathleen Sekula (Nursing Faculty Advisor)
Pat Fedorka (Nursing IRB Representative)
IRBRecords

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REFERENCES

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